THE AMERICAN JOURNAL of PSYCHIATRY

VOLUME 109
NUMBER 1
JULY 1952

Official Organ of
THE AMERICAN PSYCHIATRIC ASSOCIATION

in alcoholism . . .

Tolserol

Squibb 3-o-toloxy-1, 2-propanediol

to control tremor and quiet the patient

for relief of withdrawal symptoms

to reduce or eliminate use of paraldehyde and barbiturates in treatment

Dosage: The usual adult oral dose is 1-3 Gm. This may be repeated 3-5 times per day. The initial dose should be at the lower end of the recommended dosage range inasmuch as nausea and vomiting occasionally occur when large doses are given at the start of Tolserol therapy. Subsequent doses may be standardized in accordance with the needs of the individual patient.

Whenever possible, Tolserol should be given after meals. When given between meals, the patient should, if possible, drink ½ glass of milk or fruit juice before taking Tolserol.

Supplied: Tablets, 0.5 Gm. and 0.25 Gm., bottles of 100 and 1,000; Capsules, 0.25 Gm., bottles of 100 and 1,000; Elixir, 0.1 Gm. per cc., pint bottles; Intravenous Solution, 2%, 50 cc. and 100 cc. ampuls.

SQUIBB

THE AMERICAN JOURNAL OF PSYCHIATRY

VOLUME 109 JULY, 1952 No. 1

Published by

THE AMERICAN PSYCHIATRIC ASSOCIATION

1601 EDISON HIGHWAY, BALTIMORE 13, MD.

AMERICAN JOURNAL OF PSYCHIATRY
INFORMATION FOR CONTRIBUTORS

Manuscripts—The *original* manuscripts of papers read at the annual meetings of the Association should be deposited with the Secretary during the meetings, or sent to the New York office promptly afterward. Do not deposit carbon copies.

Papers read at the annual meetings become the property of the Association. Not all papers read however can be published in the JOURNAL, and authors wishing to publish in other vehicles will first secure from the Editor the release of their manuscripts.

Papers will not be accepted for the annual program if they have been previously read at other meetings or if they have been already published.

Papers contributed during the year (not on the annual program) should be sent to the Editor, Dr. Clarence B. Farrar, 113 St. Clair Avenue West, Toronto 5, Ontario, Canada.

Style—Manuscripts should be typewritten, double spaced, on one side of paper. They must be prepared in conformity with the general style of the American Journal of Psychiatry. Retain a carbon copy of manuscript and duplicates of tables, figures, etc., for use should the originals be lost in the mails.

Multiple Authorship—The number of names listed as authors should be kept to a minimum, others collaborating being shown in a footnote.

Illustrations—Authors will be asked to meet printer's costs of reproducing illustrative material. Copy for illustrations cannot be accepted unless properly prepared for reproduction. Wherever possible, drawings and charts should be made with India ink for photographic reproduction as zinc etchings. Photographs for halftone reproduction should be glossy prints. Illustrations should be as small as possible without sacrificing important detail. Redrawing or preparing illustrations to make them suitable for photographic reproduction will be charged to author.

Author's Corrections in Proofs—Corrections, additions or deletions made by authors are to be charged to them. These alterations are charged on a time basis at the rate of $3.00 per hour. Proper editing of original manuscript is important to avoid the expense of correction.

Tables—Tables should be typed and on separate sheets. Tables are much more expensive to set than text material and should be used only where necessary to clarify important points. Authors will be asked to defray cost of excessive tabular material.

References—References to text should be in the form of footnotes. These footnotes should be numbered consecutively from 1 up throughout the manuscript. Additional references for collateral reading should be assembled alphabetically according to author at the end of the article. Bibliographical material should be typed in accordance with the following style:

1. Van der Veer, A. H., and Riese, H. H. Treatment of schizophrenia with insulin-shock. Am. J. Psychiat., 95:-166, Sept., 1938.

Abbreviations should conform to the style used in the Quarterly Cumulative Index Medicus.

The American Journal of Psychiatry, formerly the American Journal of Insanity, the official organ of The American Psychiatric Association, was founded in 1844. It is published monthly, the volumes beginning with the July number.

The subscription rates are $10.00 to the volume: Canadian subscriptions, $10.50; foreign subscriptions, $11.00, including postage. Rates to medical students, junior and senior internes, residents in training during their first, second, or third training year, and also to graduate students in psychology, psychiatric social work, and psychiatric nursing, $5.00 (Canada $5.50). Single issues $1.25.

Office of Publication, 1601 Edison Highway, Baltimore 13, Md.

Editorial communications, books for review and exchanges should be addressed to the Editor, Dr. Clarence B. Farrar, 113 St. Clair Avenue West, Toronto 5, Ontario, Canada.

Business communications, remittances and subscriptions should be addressed to The American Psychiatric Association, 1601 Edison Highway, Baltimore 13, Md., or to 1270 Avenue of the Americas, New York 20, N. Y.

Entered as second class matter July 31, 1911, at the postoffice at Baltimore, Maryland, under the Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized on July 3, 1918.

JULY CONTENTS 1952

THE AMERICAN PSYCHIATRIC ASSOCIATION

OFFICERS 1952–1953

President: D. Ewen Cameron, M. D. — *President-Elect:* Kenneth E. Appel, M. D.
Secretary: R. Finley Gayle, Jr., M. D. — *Treasurer:* Howard W. Potter, M. D.

COUNCILLORS

For 3 years	For 2 years	For 1 year
Henry A. Davidson, M. D.	Frank J. Curran, M. D.	DeWitt C. Burkes, M. D.
Francis J. Gerty, M. D.	William B. Terhune, M. D.	Juul C. Nielsen, M. D.
Frank F. Tallman, M. D.	John C. Whitehorn, M. D.	George S. Stevenson, M. D.
Leo H. Bartemeier, M. D.	Walter E. Barton, M. D.	Harry J. Worthing, M. D.

Moderator: D. Ewen Cameron, M. D.

EXECUTIVE COMMITTEE

D. Ewen Cameron, M. D.
Kenneth E. Appel, M. D.
R. Finley Gayle, Jr., M. D.
Howard W. Potter, M. D.
William B. Terhune, M. D.
Frank J. Curran, M. D.

MEDICAL DIRECTOR

Daniel Blain, M. D., 1785 Massachusetts Avenue, N.W., Washington 6, D. C.

EXECUTIVE ASSISTANT

Austin M. Davies, Ph. B., 1270 Avenue of the Americas, New York 20, N. Y.

CHAIRMEN OF COMMITTEES

ANNUAL COMMITTEES

Arrangements
Cullen W. Irish

Nominating
Lauren H. Smith

STANDING COMMITTEES
(Internal Activities of Association)

Budget
Robert H. Felix

Constitution and By-Laws
Morris Herman

Ethics
Walter P. Gardner

Membership
Herbert S. Gaskill

Program
David A. Young

Resolutions
Ivan C. Berlien

STANDING COMMITTEES
(Technical Aspects)

Child Psychiatry
Margaret C. L. Gildea

History of Psychiatry
Gregory Zilboorg

Medical Education
Theodore Lidz

Medical Rehabilitation
Benjamin Simon

Public Health
Clifton T. Perkins

Research
Jacques S. Gottlieb

Therapy
Paul H. Hoch

Coordinating Committee on Technical Aspects
William Malamud

STANDING COMMITTEES
(Professional Standards)

Clinical Psychology
Paul E. Huston

Legal Aspects of Psychiatry
William H. Haines

Nomenclature and Statistics
George N. Raines

Psychiatric Hospitals Standards and Policies
Addison M. Duval

Psychiatric Nursing
H. Beckett Lang

Psychiatric Social Service
Jules V. Coleman

Coordinating Committee on Professional Standards
Francis J. Braceland

STANDING COMMITTEES
(Community Aspects)

Academic Education
Baruch Silverman

Industrial Psychiatry
Ralph T. Collins

International Relations
Iago Galdston

Leisure Time Activity
Alexander R. Martin

Military Psychiatry
Norman Q. Brill

Preventive Psychiatry
Erich Lindemann

Public Education and Relations
Wilfred Bloomberg

Veterans
David J. Flicker

Coordinating Committee on Community Aspects
William C. Menninger

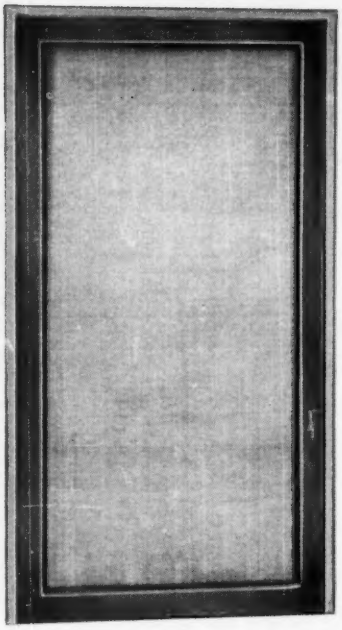
SPECIAL BOARDS

Hofheimer Prize Board
Nolan D. C. Lewis

Central Inspection Board
Mesrop A. Tarumianz

Board of Tellers
Crawford N. Baganz

Bellevue Psychiatric Pavilion, New York City



Chamberlin Security Screens (Detention type, at left) are the heaviest, most rugged made. Their extra-long life and the many savings they provide during it make them your most economical long-run security screen buy—best by far in performance, lowest by far in maintenance costs.

What *Bellevue Psychiatric Pavilion bought in its 832 Chamberlin Detention Screens*

In those 832 screens, Bellevue bought a combination of important, *measurable* advantages that only Chamberlin-designed, Chamberlin-built equipment can bring. Check these advantages against *your* needs:

1. Safe, sure, humane protection and detention year after year. That almost goes without saying where famous Chamberlin Security Screens are at work.

2. Yearly savings that figure vitally in first-cost considerations. For instance, where patients are concerned, glass breakage is stopped, grounds littering is stopped. As for the screens themselves, their extra-thick steel frames, extra-strong parts, and tough, double-crimp, stainless-steel wire mesh withstand severe beatings, usual forcing, prying, picking. Correspondingly, repair bills are cut to the bone.

3. Chamberlin Advisory Service. Architects, engineers, contractors, and institutional managements have found our Advisory Service helpful in choosing and installing the correct Chamberlin Security Screen type – Detention, Protection, or Safety – often at considerable savings. We invite you to make use of the experience we've gathered during our 14 years of specialization in this field.

Write for informative folder. Or let us give you specific information on the particular security screen installations you have in mind.

Modern institutions turn to

CHAMBERLIN

CHAMBERLIN COMPANY OF AMERICA

For modern detention methods

CHAMBERLIN COMPANY OF AMERICA

Special Products Division

1254 LA BROSSE ST. • DETROIT 32, MICHIGAN

Chamberlin Institutional Services also include Rock Wool Insulation, Metal Weather Strips, All-Metal Storm Windows, and Insect Screens

Scene from "Oliver Twist"

CHARLES DICKENS
1812-1870

Psychoneurotic Men of Genius

Charles Dickens, the renowned British novelist, was subject to cyclic moods of pronounced depression characterized by intense nervous irritability and by the shedding of tears all day long. He was exceedingly sensitive to his own experiences as well as to the suffering of others.

In the great majority of psychoneurotics, there is no serious mental illness, but merely an emotional imbalance which often can be greatly improved by proper psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is preferred by many because it combines a high degree of sedative effectiveness – producing emotional stability – with a relative freedom from side effects such as languor and drowsiness. Patients usually become calmer, more cheerful and better adjusted to their surroundings without clouding of mental faculties.

Average sedative dose:
Adults, 32 mg. to 0.1 Gm. (½ to 1½ grains) three or four times daily;
children, 16 to 32 mg. (¼ to ½ grain) three or four times daily.

Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

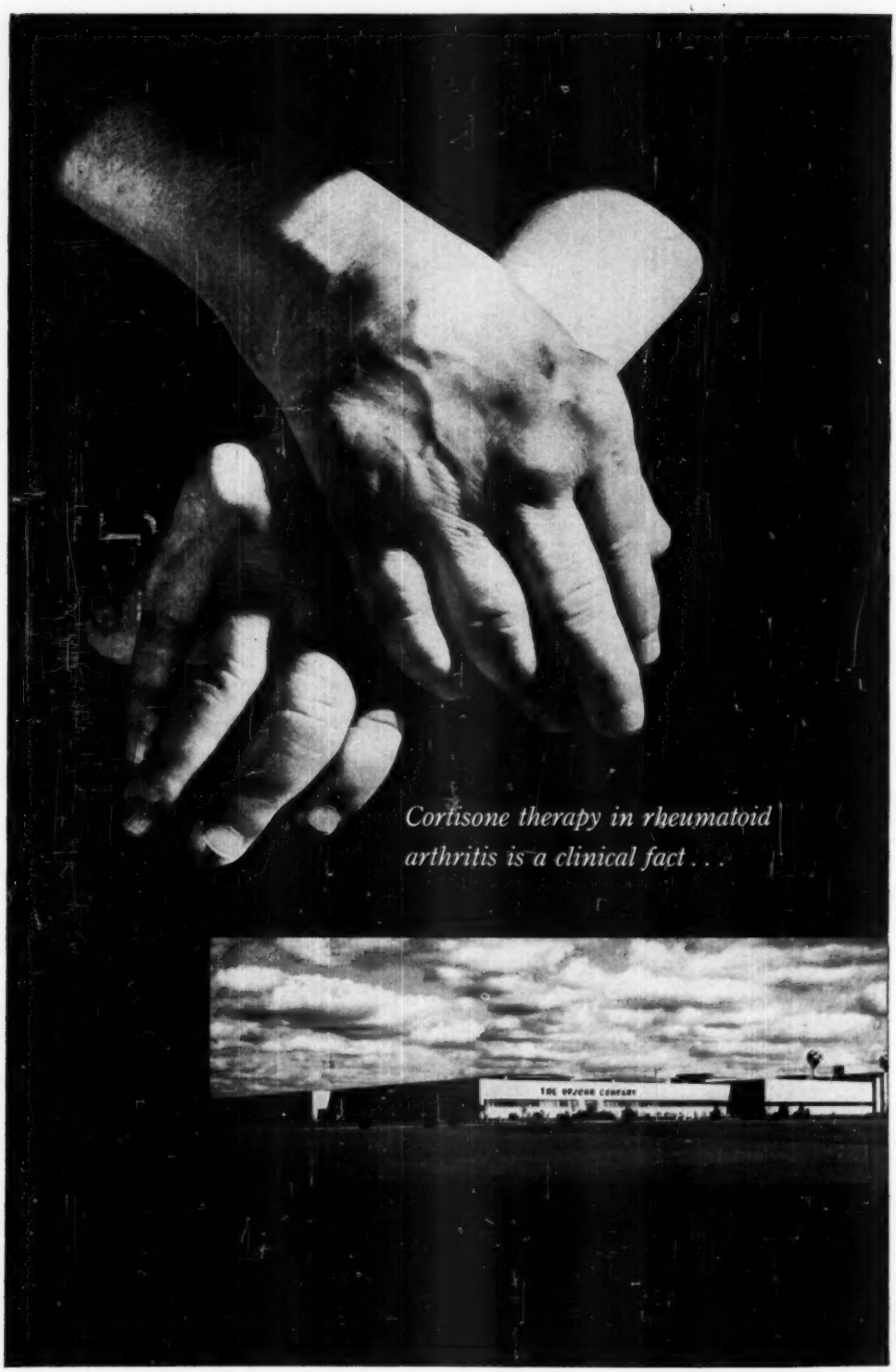
Mebaral

tasteless daytime sedative

EFFECTIVE ANTIEPILEPTIC

Winthrop-Stearns INC. New York 18, N. Y. • Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital


Cortisone therapy in rheumatoid arthritis is a clinical fact . . .

No. 5 of a series

In the treatment of alcoholism with "Antabuse"...

Q. Does "Antabuse" potentiate the sedative effect of barbiturates?

A. No. We have seen no clinical evidence that there is a potentiation of the sedative effect of barbiturates by "Antabuse" when both drugs are used in ordinary therapeutic dosages. In animals, however, a potentiating effect has been shown but only when doses of barbiturates far beyond the clinical range were employed.

The above is typical of the countless questions received from the medical profession. Should you require further information regarding this or any other aspect of "Antabuse" therapy, please feel free to call on us. Descriptive literature is available on request.

"ANTABUSE"®

Brand of specially prepared and highly purified tetraethylthiuram disulfide

...a "chemical fence" for the alcoholic

Supplied in tablets of 0.5 Gm., bottles of 50 and 1,000

Ayerst, McKenna & Harrison Limited
New York, N. Y. • Montreal, Canada

5230

Leo. L. Bartemeier.

PRESIDENTIAL ADDRESS

LEO H. BARTEMEIER, M. D., DETROIT, MICH.

It is now seven years since World War II came to a military end. We brought into the field of war medicine the psychiatric knowledge we had acquired at home, and we gained a great deal of psychiatric experience from our work in the armed forces. As a matter of fact, it is not quite certain whether American psychiatry contributed more to the screening and mental health of our armed forces during the war than it learned about human beings through its military work. Whatever the case may be, there is no doubt that as a result of the last war American psychiatry acquired a mass of valuable clinical knowledge; it developed its sphere of influence beyond the problems that combat psychiatry offered; it acquired a number of new skills; and its ingenuity in the field of organization and preventive work has grown immeasurably.

Our own awareness, as well as that of the government and the public, that we need more and more psychiatrists, and better and better psychiatry, has become acute. Before the last World War this was felt only in a very general way, and mostly by the psychiatric profession itself. We have grown in numbers; our membership has almost doubled. And with the growth in numbers and skills and methods, our problems have also grown. Psychiatry today has a great deal more to do, but it has many more difficulties —which is natural because the more work people do, the more problems they have to meet.

The major problem, as it presents itself to me, and I am sure to a great many if not the majority of the psychiatric profession, is the problem of psychotherapy. This does not mean that I am inclined to overlook the many biological and clinical, not to say technical, difficulties that are the lot of those who use various pharmacological, electric, and surgical methods of approach to the treatment of psychoses and neuroses. These methods are limited in their application by their effectiveness. The empirical results of these methods will ultimately guarantee their success or failure; clinical criteria that these methods use are by their very nature an excellent check against unwarranted enthusiasm— although one must be careful not to overlook the fact that the need for better clinical psychiatry is here felt with ever-increasing intensity. For what happened in this field is this: the physiologist, the internist if you will, the neurologist, and the neurosurgeon took over the task of treatment; but the task of assessing the indication and the degree of clinical change as a result of the given treatment must remain in the hands of the psychiatrist, or else the treatment becomes too impersonal. What greater scourge could befall psychiatry than becoming impersonal— which means losing sight of the person of the patient? The great technological advances that have taken place in medicine within the last three-quarter century raise this threat—the loss of the personal relationship with the patient. The whole tradition of medicine is based on healing and caring for the sick as persons, through constant personal contact between the doctor and the patient.

Today we in psychiatry are aware of this tradition more keenly than in many other branches of medicine. The cultivation of the personal, humanistic contact with the patient has been maintained in psychiatry, because human psychology and human problems are still our major point of interest. Scientific precision, scientific instrumentation, and scientific objectivity are not as easy to achieve in psychiatry as in other branches of medicine. As doctors we await with the greatest eagerness and welcome with greatest enthusiasm every new scientific development, but in our eagerness and enthusiasm we must not fail to scrutinize each scientific innovation with respect to its impact upon that oldest and best medical tradition— the personal relationship with the patient. Every scientific discovery, every technological innovation, every new refinement in diagnostic accuracy, every new therapeutic technique, diminishes the personal aspects of medical care. I regret to have to state that the value of the relation-

ship between doctor and patient has all too often vanished from the scene, where enthusiasm for mere technology has taken the place of truly scientific humanism. It so happens that what the technologist is apt to consider "unscientific" is still the major ingredient of psychotherapy. Much good came and continues to come from our scientific advancement, but it carries with it certain regrettable features, against which we must always be on guard. Thus, to cite one of many examples the hospitalization of obstetrical patients has produced a remarkable reduction in the mortality of parturient mothers and newborn children; at the same time, the separation of the newborn from their mothers, particularly since the establishment of hospital nurseries, has increased the amount of unnecessary anxiety both in mothers and children and has laid down the foundation for preventable future disturbances of mother-child relationships. All these untoward results came by way of the displacement of our interests from the persons who are sick to the physiological processes of the patients. Personal factors have thus been sacrificed on the altar of scientific advancement.

Now, psychotherapy, the most personal of all healing arts, is certainly not a new development in psychiatry. As a matter of fact, it is the oldest therapeutic approach in cases of mental diseases. Whether we knew it under the name of "spiritual dietetics" some hundred years ago, or "moral treatment"—a term used for almost 150 years—whether we knew it from descriptions without a name made by doctors in the sixteenth or seventeenth century, or under the name of mesmerism, or hypnotism, or more recently psychoanalysis—a specialized form of psychotherapy—psychotherapy has always been the keystone of psychiatry, which wished to bridge the chasm between so-called normality and mental alienation.

The trouble, we must be frank and admit, is that psychotherapy still remains a rather vague concept. There is so much that is unclear about it, that many think of it in derogatory or even derisive terms. At the Conference on Graduate Education in Clinical Psychology held at Boulder, Colorado, in August 1949, one of the participants made the following rather facetious remark: "Psychotherapy," he said, "is an undefined technique applied to unspecified problems with unpredictable outcome. For this technique we recommend rigorous training." This barb thrown at psychotherapy at a serious conference, even if it was made in good humor, still reflects a not uncommon attitude. And let us again be quite candid and admit that somewhere, somehow, we do feel that there is some degree of truth in this facetious jab. The attitude it expresses is not foreign to certain quarters of the medical and even the psychiatric profession, as well as the general public. We will do well if we abandon some of our false pride and further admit that the degree of scepticism and even ridicule with which psychotherapy is met at times is not wholly unjustified. For psychotherapy as we know it today is a new development in psychiatry. It came and conquered psychiatry, so to speak, and it grew so rapidly that it may be looked upon as a precocious child that grew too fast both physically and intellectually but is still a child, and still has much to learn. The parents of such a child have a greater responsibility than they would have in relation to a normally or even slowly developing child. For the precocious child is more apt to grow too fast to develop proper self-discipline, and it is the task of the parents to be intelligent enough to hold the child in a manner of restraint without impairing its growth, and to let him learn without his losing the desire to be taught. Psychotherapy as it is conceived and practiced today is the precocious child of psychoanalysis and psychiatry; it is the responsibility of these parents to prevent it from becoming an amateurish, free-for-all psychological indulgence, and to make it a disciplined, systematized branch of psychiatry. The responsibility for this task will have to be shouldered primarily by psychiatry; for psychoanalysis is after all a specialized method of treatment, a highly specialized one, and it is the psychoanalyst's job to train psychoanalysts. The training required to become a psychoanalyst is long and rigorous, and it is centered around the specific goals that psychoanalytic therapy envisages. It is therefore primarily the responsibility of psychiatry to learn to train psychotherapists. The problem is serious and complex, and I would wish to sketch before you some

of the highlights of its general history, and some of the dark spots too. In full consciousness of my responsibility, I do this with malice toward none and with charity for all, but I feel it is incumbent upon me to try to speak my mind, not because it is my mind but because I know it is the serious concern of many whose responsibility it is to head mental institutions and train psychiatric residents, of the residents themselves, and of those of us who are concerned with the soundness of our patients' health, and of our educational methods and of mental health in general.

As I have already intimated, psychotherapy as we know it today is an outgrowth of the last war. Before the war psychoanalysis was growing in popularity, but fundamentally it remained more or less isolated. Psychoanalytically oriented psychiatrists (of whom there were few) and psychoanalysts who had good psychiatric training (of whom there were even fewer) did exchange information and did try to work together, but the two fields (psychoanalysis and psychiatry) remained far apart. True, less than 30 years ago we had a president of our Association whose knowledge and teaching of Freud was of the highest intellectual and clinical order. But the contributions of William A. White, and of his life-long associate Smith-Ely Jelliffe, to the formation of psychoanalytic psychiatry were mainly in the field of theory.

The organization some 20 years ago of a Section on Psychoanalysis in the American Psychiatric Association was a sign of the increasing interaction between psychoanalysis and psychiatry; each granted the other diplomatic recognition, so to speak, and each granted the other that diplomatic immunity called extraterritoriality. Thus psychoanalysis remained an autonomous island on the continent of psychiatry, and psychiatry enjoyed the status of a sort of home rule in the psychoanalytic subcontinent. However, this state of affairs marked a considerable advance over European psychiatry, which remained solidly separated from psychoanalysis and kept psychoanalysis in a state of abnormal isolation. Yet the recognition mutually accorded by psychoanalysis and psychiatry in America did not always mean that the relationship between the two was more than diplomatic—and at times it was not even that. There were few psychoanalysts teaching psychiatry prior to 1941. The teaching was mostly limited to the undergraduate classes in medical schools, and what was taught was watered down considerably in order to make it sound more or less acceptable. The opposition, both official and emotional, was still too great.

The war came. Psychoanalysts, quite a number of them, were called to the colors; they served and functioned as psychiatrists in the armed forces. The psychiatrist and the psychoanalyst met under fire and they worked together; they met the clinical problems together and had to solve them in common; they exchanged their views; they shared their respective knowledge. Professional barriers were thus eliminated; a relationship was established that was both closer and more understanding than it had been in civilian life before the war. Military psychiatrists were led to admire the clinical insight and competence of those of their colleagues who had psychoanalytic training. The clinical approach and therapeutic skill that the psychoanalyst showed in dealing with the military personnel who were ill did not pass unnoticed, and the old-fashioned psychiatrist did not fail to benefit by this new professional intimacy.

The war over, the psychoanalysts returned to civilian life but maintained with the psychiatrists the close relationship that had been established during the war years. Psychoanalysis was no longer isolated. A great number of psychoanalytically trained men joined the faculties of a number of medical schools. Under- and postgraduate teaching was intrusted to them, both in medical schools and in mental hospitals, which re-established themselves as training centers of residents. Many local psychiatric groups and societies of practicing psychiatrists began to collaborate with psychoanalysts, and the latter began to take active part in the scientific programs of mental hygiene organizations all over the country. A number of psychoanalysts were asked to supervise the treatment interviews of practicing psychiatrists, after the manner of psychoanalytic candidates in training in Psychoanalytic Institutes. Thus, rather

quickly, psychoanalytic theory and techniques become popular and attached themselves to, or rather were incorporated into, the body of American psychiatry.

Simultaneously, another trend came into evidence. A number of psychiatrists upon their return from service in the armed forces either sought complete psychoanalytic training in the several Psychoanalytic Institutes, or tried to gain the more limited experience and goal by having a personal therapeutic analysis. Only a small fraction of those who started their training were found suitable to become accredited psychoanalysts, but a large number had the benefit of a personal analysis—which gave them an intimate contact with, if not complete insight into, the intricacies of psychoanalytic psychology.

We must remember that for a long time our basic psychiatric training, which was devoid of any psychoanalytic orientation, offered the resident little knowledge, little appreciation of the meaning of the hospitalized patient's talk. Moreover, the training of residents lacked any formal program, any guiding principle or system. The resident in psychiatry was often left largely to his own devices, and what he did learn was often by means of trial and error and purely personal improvisations.

But the residents themselves must have begun to feel the need of more systematized and consistent training to supplement their years in mental hospitals. This need too was one of the most potent factors in bringing about the changes in the orientation of which I have just spoken, and which left its mark particularly on this last decade.

It is not an exaggeration to say that clinical psychiatry in America, particularly the private practice of psychiatry, has become psychoanalytically minded. And as happens so often with a new development, the enthusiasm for the new produces a distorted perspective on our scientific inheritance as a whole. A myth has become prevalent, not frequently outspoken but always felt, to the effect that unless one is a psychoanalyst one is some kind of psychiatric failure. This is the reverse side of the medal. This is the retrogression that accompanies so frequently every scientific advance in medicine. The myth betrays both a state of enthusiasm and a state of anxiety—as if the believer in this myth says to himself: "If psychoanalysis is the thing, then psychiatry ought to be abandoned." The effect of this attitude is unfavorable both for psychoanalysis and for psychiatry. It is unfortunately quite common to find that psychiatrists in private practice follow more their enthusiasm than their better judgment and clinical sense, and that they are in fact conducting what is known as wild analysis. The reputation of psychoanalysis cannot help but suffer as a result of this practice, because the general public, and even a number among the medical profession, do not know the difference; seeing the strange effect a wild analysis has on the patient as well as on the psychiatrist who practices it, they are apt to condemn the field of psychoanalysis, and its scientific advancement suffers a corresponding setback. The overindulgent and uncritical enthusiasm for psychoanalysis that gives rise to wild analysis does a great deal of harm to psychiatry, since psychiatry is being abandoned in the process. Certain technical steps forward in medicine had a similar effect on the practice of medicine. The simple transposition of psychoanalytic theory into the practice of psychotherapy tends to center the attention of the psychiatrist during his interview with his patient on the analytic mechanisms and concepts rather than on what is taking place between himself and the patient. His attention is diverted to this or that mechanism or this or that form of the oedipus complex. The psychiatrist, through this diversion, is also diverted from even noticing his own anxiety about his attitude toward the patient, or the patient's anxiety in relation to the therapist. In a word, attention is diverted away from the patient as a sick person and is concentrated on him as a bundle of psychological mechanisms.

It is obvious that under these circumstances the effectiveness of the psychotherapy and of the psychotherapist is considerably diminished, if it does not go down entirely to zero. The general enthusiasm for psychoanalytic procedures, even if they are wild, and the inadequacy of therapeutic results drive one into general theoretical thinking. This is reflected in the various clinical reports in which we see such an overabundance of tech-

nical language and a true paucity of facts about the patient himself. The patient as a person, his illness as a handicap and a source of discomfort, his personal and interpersonal difficulties seem to fade away in the fog and snow of technical terms.

As you see, here again the result is that we have lost sight of the patient while keeping our sight trained on the novel technique. How can psychotherapists under these circumstances continue to remain professionally sound and happy? Yet it is true that a certain type of psychoanalytic therapy has become so popular that all other psychotherapeutic methods are often looked upon with disfavor and regarded as a waste of the therapist's time. It is, however, a greater waste of the therapist's time, and almost certainly injurious to a great many patients, to use psychoanalytically oriented psychotherapy at any cost, by applying it to certain types of patients who are not suitable for this sort of therapy.

I am fully aware that the psychoanalysts who hear me say all this may find me too skeptical, and the psychoanalytically oriented psychiatrists might find me rather carping. Let us look at the facts as they really are, and I am sure that few if any would find themselves in real disagreement with me. I have had bestowed upon me many honors that I do not deserve, and I endeavored, with all the candor and self-criticism that I was able to marshal, to assess with humility but with frankness the experiences that the honors and positions have vouchsafed me. Therefore, having served as President of the American and International Psychoanalytic Associations and then as President of the American Psychiatric Association, I cannot help but feel that the psychoanalytic infiltration into psychiatry was too rapid to be clinically as useful as it might have been, and as it will some day be. Similarly, I cannot help but feel that the psychiatrist who does psychotherapy is often too ready to shed some of the older and always useful tools with which he had worked in order to gather information and in order to exert a therapeutic influence on the patient.

The old and very good habit of taking carefully a complete anamnesis seems to have become attenuated; interviews with relatives are well-nigh abandoned by certain psychotherapists as being out of date. Maintenance of good relationship with the family physician, and the manipulations of the patient's environmental conditions, have begun to be considered inadvisable. All these things put together present a sorry picture of ill-advised imitation of the psychoanalyst. Such imitations are equivalent to complete abandonment of psychiatry in favor of a certain illusory psychoanalytic respectability. The psychoanalyst has his work cut out for himself and by himself; he accepts only suitable cases, that is to say, cases whose prognosis appears favorable under psychoanalytic therapy. The psychiatrist, on the other hand, has the whole field of clinical psychopathology in his lap, and he must deal with it; his is the problem of helping and caring for the psychologically compromised, for the delinquent, the social deviate, the so-called borderline-case. His is the problem of rehabilitation and of preventive work. And he must be able to do his work with his own tools; no matter how sharpened those tools might be by the deeper psychological insight that psychoanalytic psychology provides. Those tools are the psychiatrist's own, and he must learn how to use them on his own.

The nature of psychoanalytic therapy is such that life-experiences and new vistas and knowledge are uncovered as the treatment develops and as the therapeutic results begin to show themselves. It is all a slow and painstaking procedure. But the problems with which the psychiatrist has to deal frequently endanger the well-being and safety of the individual and of society. Only in very special cases, or under very special intramural conditions, might it be possible to carry out psychoanalytic treatment without harm being done to the patient or to the environment. But psychiatric patients and problems, despite their intricacies, are seldom offered us under the optimum conditions that are favorable for psychoanalytic therapy. The whole field of psychosomatic medicine is a field replete with psychiatric and physiological emergencies that make serious demands on the psychotherapist, and that cannot be fitted into the strict psychoanalytic routine. A bleeding gastric ulcer, a possible coronary occlusion, serious respiratory dif-

ficulties, definite—though ambulatory—suicidal risks, delinquents, impulsive transgressors of the law (which include sex offenders), addicts of varying degrees of severity (including alcoholics), so-called neurotic characters who must go on working to support themselves and who are neurotic failures—and a host of other conditions too many to be enumerated here all require skillful therapeutic handling by the psychiatrist. It is here that the psychotherapist finds himself confronted with many tasks to which he must be equal.

To make the psychotherapist equal to these tasks, we must develop a special program for the training of psychiatric therapists. Heretofore, there was no program inclusive enough to be worthy of its name. This program for psychoanalytically oriented psychiatric psychotherapists must begin within the walls of our hospitals—during residencies. Such programs, to be effective, will have to include not only the study of that which psychoanalysis and psychiatry have in common, but of that which they do not have in common. What these two fields have in common ought not to be taught in a manner as if one must absorb or overwhelm the other; and that which separates them ought not be taught as if one must be rejected in favor of the other. Psychiatry will always remain a separate branch of medical science, regardless of how full a recognition is accorded psychoanalysis. And both would sustain immeasurable losses if they were to return to the conditions of a generation or so ago when they tried to disregard or even to abolish one another.

We must admit and recognize the full extent and the full value of the historical fact that psychoanalysis and psychiatry have become interlaced in their activities. They have become fused as far as clinical psychopathology is concerned. It is the practical delineation of the clinical borders that has not been fully worked out. This is our most urgent task. The skill, the technique with which psychiatric therapists could utilize their psychoanalytic orientation have not yet been perfected. In accredited psychoanalytic training, we have developed certain safeguards against the future analyst's blundering. These are the personal analysis and supervised work. Whether the psychiatric therapist should be advised to undergo a personal analysis is a question that cannot be answered without reservations. All depends upon the personality of the psychiatrist, his clinical acuity, and his neurosis, if present. Each individual will have to be considered separately and on his own merits. Certain it is, however, that a psychiatric therapist must follow carefully some regime of mental hygiene that would safeguard him against the intrusion of his own personal, mostly unconscious, problems in his relationship with the patient, the patient's relatives, and the family doctor. We have not yet worked out such a regime of mental hygiene. This we will have to study and accomplish in the nearest future. It cannot be done too soon. This regime will have to be established at the time the young psychiatrist starts his residency in a mental hospital. As a matter of fact, this is the best time to start, because it is during the psychiatric residency that the physician has all the advantages and discomforts of frequent and numerous impacts coming from a great number and variety of patients.

Too, we might take a leaf from the history of psychoanalytic education and Institute-supervised therapeutic work during the initial stages of private psychiatric practice. Some 30 years ago Psychoanalytic Institutes established the principle of so-called control work. The young analysts would do their first analyses under the supervision of older and especially accredited colleagues. It was only after a sufficient amount of such supervisory work was done that the analyst was allowed to start or to continue on his own. This practice has been continued to date with a number of refinements and elaborations—from individually supervised work of an individual case, to supervision in groups and so-called continuous case seminars in which one case treated by one man is supervised for a period of months. The anonymity of the patients is of course fully protected in this supervised work.

The psychiatric therapist would benefit a great deal from doing such supervised work; so would psychiatry as a whole. So would our patients.

As you see, the suggestions that I have made bold to put forth in the hope that our psychotherapy will be improved and its effectiveness enhanced—that is to say, in the name of progress—are actually an appeal for the restoration of the oldest tradition of medicine and medical teaching; the direct contact between teacher and student (both of whom are here envisaged as mature and seasoned doctors), also and primarily the direct contact with the patient. It is a form of true bedside clinical teaching adapted, to be sure, to special conditions of psychiatry, but without compromising our true interest in the man who is sick and in the therapeutic care that we owe to the patient.

LEO H. BARTEMEIER, M. D.

President, 1951-1952

A Biographical Sketch

HENRY W. BROSIN, M. D., Pittsburgh, Pa.

The current President of The American Psychiatric Association has such prodigious industry that merely a telegraphic recital of his activities would occupy all the space available to us here to become better acquainted. His modesty and quiet dignity have brought him consistent recognition from his colleagues in several fields, assuring him of a firm place in the history of contemporary psychiatry.

Born on September 12, 1895, in Muscatine, Iowa, to John Albert Bartemeier and Katharine Schaab, he grew up in this predominantly German Catholic farming community. The oldest of 4 living children, Barty was early trained to work both at home and in his father's hardware store and learned about business and civic affairs through his father's numerous activities. His paternal grandparents had migrated from southern Germany bringing with them the habits of industry that are so evident in all members of the family. His father, in addition to his active business and domestic life, was prominent as an alderman, officer in the Knights of Columbus, bank director, and was petitioned to become the mayor of the city but he declined becoming a candidate. His maternal grandfather was a well-to-do farmer although he had migrated from Germany after completing a university education, for he intended to become a teacher. Trained in the classics he continued to read both Latin and Greek throughout his long life, lent books to Barty, and encouraged him to continue his education. This he did even though the urge to support himself grew with the years. At eleven, he had a large newspaper route that he delivered before breakfast 6 mornings a week. Three years later he became a cub-reporter for the *Muscatine Journal* during the summer vacation. At 16 he worked one summer as a private secretary to an efficiency engineer in a factory. Graduating from the eighth grade of the German Catholic parochial school before his thirteenth birthday, he entered St. Mary's College, a Jesuit boarding school at St. Mary's, Kansas, where he remained until June, 1913. During these 5 years he completed the work of 4 years high school and the first 2 years of college. In addition to the required courses he also studied shorthand and typewriting, enabling him to take additional jobs as a public stenographer and for the Associated Press, which helped him through college. He was able to do the work of the junior college year while preparing for examinations during the summer and was thus able, after passing these examinations, to matriculate as a member of the senior class of the Catholic University of America in September, 1913. The A. B. degree was awarded him in June, 1914, at the age of 19. After winning a Fellowship in a competitive examination, he began a research project in the graduate school in experimental animal psychology using 45-day-old rats to work out a problem in "The Doctrine of Pleasure-Pain in Learning." This work was completed in 1916, at which time he received his Master of Arts degree.

During these 2 years Dr. Bartemeier became friendly with a general practitioner and his family and was influenced by this genial physician to study medicine instead of completing his work for a doctorate in psychology. He entered Georgetown Medical School in 1916, meanwhile working in the laboratory at Garfield Memorial Hospital and also as an assistant to the professor of physiology. Later, in addition to other jobs, he lived at the Children's Hospital doing laboratory and ward work.

After graduation from medical school in June, 1920, he accepted an internship at the Henry Ford Hospital in Detroit. In 1921 he was in charge of the medical internes, and from 1922 to 1924 he served as assistant to Dr. Frank J. Sladen, the physician-in-chief in the department of medicine. Dr. Sladen's broad concept of illness and interest in the

psychological aspects of medical problems influenced Dr. Bartemeier to seek training in neurology and psychiatry. He spent 2 years with Adolf Meyer at the Henry Phipps Psychiatric Clinic at Baltimore, studying neurological anatomy and doing some research on "Decerebrate Rigidity in the Sloth" (Brain, 49:207, 1926) with Dr. Curt Richter, in addition to the customary psychiatric duties.

Dr. Bartemeier then returned to Detroit to enter the private practice of psychiatry. He took offices in the General Motors Building on July 1, 1926, and has remained in them ever since. In 1930 he became so dissatisfied with his results in psychotherapy that he began a personal preparatory analysis with Dr. Franz Alexander of Chicago, Illinois. He commuted between Detroit and Chicago in order to continue both his practice and his training under control analysts, and to complete the lectures and seminars at the Institute for Psychoanalysis. He was a charter member of the Chicago Psychoanalytic Society and became a training analyst in 1938.

Since completing his psychoanalytic training, Dr. Bartemeier has divided his time between psychiatric teaching, psychotherapy, and training analyses. He is associate professor of psychiatry at Wayne University School of Medicine, the first visiting professor of psychiatry at the University of Michigan, director of postgraduate training in psychiatry at Pontiac State Hospital, conducts clinical seminars under the auspices of the Detroit Psychoanalytic Institute for psychiatrists at The Haven Sanitarium, is on the advisory committee of the Veterans Administration, and is on the staffs of the Bon Secours and Henry Ford Hospitals. For the past 5 years he has been chairman of the Josiah Macy, Jr. Foundation Conference on Problems of Infancy and Childhood. From 1926 to 1931 he served on the staff of the outpatient clinic at the Harper Hospital, and from 1926 to 1933 was director of the mental hygiene clinic for children under the auspices of the Society of St. Vincent De Paul. He established the veterans clinic at Harper Hospital in Detroit in 1945, which continued until 1947 when it was absorbed by the adult psychiatric clinic supported by funds from the Community Chest and the State Mental Health Authority. These and other organizational activities have given him ample scope for developing his interests in teaching and clinical research.

Dr. Bartemeier's publications reflect his manifold activities. Many of these are in the field of child psychiatry, war neuroses, industrial and general psychiatry, but his more specific clinical studies appeared as follows:

The Neurotic Character as a New Psychoanalytic Concept. Am. J. Orthopsychiat., **1**: 512, 1931.

Some Observations of Convulsive Disorders in Children. Am. J. Orthopsychiat., **2**: 260, 1932.

Concerning the Psychogenesis of Convulsive Disorders. Psychoanal. Quart., **12**: 330, 1943.

A Psychiatric Study of a Man Suffering from a Convulsive Disorder. Bull. Menninger Clin., **7**: 62, 1943.

Freud's Contribution to the Problem of Mental Heredity. Bull. Menninger Clin., **6**: 190, 1942.

A Psychoanalytic Study of a Case of Chronic Exudative Dermatitis. Psychoanal. Quart., **7**: 216, 1938.

A Counting Compulsion. Internat. J. Psycho-Anal., **22**: 301, 1941.

Micropsia. Psychoanal. Quart., **10**: 573, 1941.

Illness Following Dreams. Internat. J. Psycho-Anal., **31**: 1, 1950.

Another publication that will be of continued interest while we are in a state of war is the report written by Drs. Bartemeier, L. S. Kubie, K. A. Menninger, John Romano, and J. C. Whitehorn following their experiences in the European Theater from April 20 to July 8, 1945. The report was entitled, "Combat Exhaustion" (J. Nerv. Ment. Dis., **104**: 358, 489, 1946). The papers on "The Contribution of Psychiatry to Psychoanalysis" (Am. J. Psychiat., **101**: 205, 1944) and "Psychiatry and International Understanding" (Am. J. Psychiat., **107**: 641, 1951) present some of Dr. Bartemeier's principal current interests. Stimulated by his work as chairman of the Macy Foundation Conference on Problems of Infancy and Childhood and his war experiences in Europe, he has broadened his perspectives to modern psychiatric education in other countries. In August 1950 he served as a consultant from the World Health Organization upon the request of the Irish government to study the possibility of establishing psychiatric services for children in Ireland. His interest in this continues and at present he is training

2 young Irish physicians who will eventually return to Dublin to practice. It is hoped that more physicians will be trained for Ireland and other countries, notably Cuba. Currently, Dr. Bartemeier is a member of the Executive Board of the World Federation for Mental health. The strengthening of international relations in psychiatry is now one of his major interests.

Our President worked hard as Secretary of the American Psychiatric Association during the active years from 1946 to 1950. He is also on the Executive Council of the American Psychoanalytic Association after having been Secretary 1942-1944 and President 1944-1945. He was President of the International Psychoanalytic Association from 1949 through the Amsterdam Congress in August, 1951. He was President of the Detroit Psychoanalytic Society from its organization in 1940 until 1946 and is now Vice-President and a member of the educational committee. He is an associate editor of the *International Journal of Psycho-Analysis.*

Other organizations in which he has played a prominent part are the Michigan Society of Neurology and Psychiatry, The Cornelian Corner, Group for the Advancement of Psychiatry, Menninger Foundation, William Alanson White Foundation, National Advisory Mental Health Council, and The Psychiatric Foundation.

Friends of Dr. Bartemeier have no difficulty in understanding why he should be honored so frequently by high office. Tall (6 feet, 2 inches), broad-shouldered (225 pounds), erect, gentle in movement and soft of voice, he inspires confidence by his presence. Conscientious about his duties he brings dignity and fair play to a job that is appreciated by the membership. He pays a considerable personal price for serving his fellow man since he must also earn a living. Few men can get up every week day at 5 A.M. in order to see the first patient at 6:15 A.M. and work through the entire day and evening. But beneath the serious mien there is a steady flow of humor and a love of fun. Formerly an ardent fisherman, he is now keen about photography and stamp collecting. He works in the garden of his beautiful home and has shown some talent with clay and sketching but deprecates his abilities in these fields. Time does not permit much cultivation of music or art although he has a collection of art, literature, and etchings, and attends concerts whenever possible.

On November 23, 1921, Dr. Bartemeier married Elizabeth Haltigan in Washington, D. C. They had 3 children. Mary (Mrs. William L. Hurley) brought joy to her parents when the first grandchild, Ann Elizabeth, arrived last year. John died suddenly of an aneurysm of the Circle of Willis, at the age of 18, in 1945. Katharine lives at home and works as a secretary.

THE STUDENT COUNCIL STUDY

An Approach to the Normal [1]

EARL D. BOND, M.D., Philadelphia, Pa.

The ideas that psychiatrists have about human nature have come mostly from observations of people who selected themselves, or were selected by others, because they were in serious trouble. And there are on record few psychiatric studies of happy and successful people.

"Until normal people, happy and engrossed in their human relationships and work, have been studied with some of the perspicacity and thoroughness that have been expended on the troubled and deviant, speculation about mental health must remain highly tentative." [2]

William Healy (1) made a record of a successful young man and decided that the man's ambition came from internal tensions (rejected by his mother) "which for their relief" sought "unremitting effort" which could be managed by a "splendidly functioning organism."

A valuable study of a college group was made at Harvard by Dr. Arlie V. Boch,[3] the Dean and the physicians selecting about 74 successful and normal students from several sophomore classes. Two hundred and fifty-two men were intensively investigated and followed for 10 years—the latest reports being made by a cultural anthropologist after a visit to the home of the former students.

This Harvard experiment was too large for me to repeat and I wanted a different method of selection and to include women and men on equal terms. I was near Haverford, Bryn Mawr, and Swarthmore Colleges (for men, women, and coeducational) and knew that they carefully picked their beginning classes. I supposed, correctly, that they had student councils to which representative students were elected. The 3 councils for 2 years were asked to volunteer and one person only stayed out: 64 came in to meet the psychiatrist for several hours, to take Rorschach and TAT examinations, and to prepare their families for a social worker's visit to their homes.

Here was a group chosen by 2 selections with which the examiners had nothing to do. One college president commented, "It is as normal a group as you'll ever get."

The difficulties in getting a better group will be great. It has been suggested that this group is overweighted in intelligence—that a group might be picked out of the streets. But when I think of the help that was offered by intelligent students and parents I feel overwhelmed at the idea of trying to explain to citizens taken at random the purpose of the undertaking and the reasons for their cooperation. It has been suggested also that medical students would easily give cooperation, but they would be mostly men with one purpose and behind them a college career of studies focused on one narrow goal. I hope better groups will be found but I have not heard of them.

The advantages of the council group became more apparent as work went on. It was an unexpected help to be able to go to regular council meetings to discuss arrangements and answer questions. Then the ages of the students meant that parents were caught at a favorable time when they were thinking of the students as independent persons removed from the family setting and yet when they could remember the events of the students' childhood.

Method

In an effort to avoid "looking for trouble" the following outline was given for the psychiatric interviews with the students.

1. Get a description of the family and the characteristics of grandparents, parents, brothers and sisters (and others if possible).

2. Get a personal history—by years and by stages (infancy, childhood, 6-12, 13-17, college).

3. In a personality study get (a) native abilities, (b) motivations, aims, career plans, (c) self-estimate—in different fields, (d) habitual ways of

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

Supported by the William T. Grant Foundation. From the Institute of the Pennsylvania Hospital.

[2] Brewster Smith.

[3] A consolidated report is soon to be published.

meeting difficulties, (e) mood dominance. Ask the question, "What is a grown-up person?"

4. Get a usual day's routine—at college, in vacation. Ask about religious, political, sexual training and development, fears, prejudices, recurrent or memorable dreams, aggressiveness, anxiety, hostility, interest that goes outward.

5. Note appearance, body type, neatness, speech, social ease.

Results

In a preliminary report (2) of the findings of this investigation into the generations before the students, it was considered remarkable that there were no psychoses in the parents and only 2 (a mild and a severe depression) in the grandparents. But neurotic traits in all generations were evident without the help of the Rorschach and TAT tests, which were interpreted after the first report was made. In a group of 60 college students admitted to the Pennsylvania Hospital for Mental Diseases there were 25 psychoses in parents and grandparents.

An over-all impression of the students is that all 64 are on their way to good citizenship. Their outstanding and undoubted asset is intelligence (SAT verbal scores 823 to 487; mathematical 720 to 363).

In viewing the assets and liabilities of this group we must remember that the long list of liabilities is made possible by the assets of the students and their parents. And the students had 3 searchlights turned upon them—psychiatric interviews, histories from parents, and psychological tests.

Following the good advice of Dr. Katharine McBride I have given up an early notion of lining up the students in 1-2-3 order. There is nothing in psychology to act the part of a prism in breaking up light into a spectrum. But there is a natural, inexact division into 4 groups, as follows:

I. There is a group of women for whom some of the Rorschach words are "good mind, lively imagination, rare, exquisite, creative, excellent potential," while the psychiatrists' words are "loyal, altruistic, good citizen." In these women there is at most a slight moodiness and in some a (proper?) hostility.

The corresponding group of men contains several older than the average because of military service in which they showed courage and stability under stress. Words in the Rorschachs are "good inner resources, good minds, rich and vigorous, clear and orderly thinking, strong, and spontaneous instincts." Words from the psychiatrists' interviews are "friendly, steady, idealistic, handles people well." In these men can be seen slight hostilities and slight depressive tendencies.

In this total group liabilities appear completely overwhelmed by assets.

II. Then there is a group where the women are described as "warm, attractive, conforming, realistic, modest with mild drives, sensuous, amicable" while the men's abilities and ambitions are modest. All of them are steady and well adjusted and show the very slightest signs of uneasiness.

There are a very few men who seem extremely well balanced on a very low level: that is, they are commonplace, shallow, smooth, successful.

III. About a fourth of all the 64 students have in common extraordinary abilities and important neurotic traits. Descriptions of the women carry the words "richly creative, popular, altruistic, attractive, charming, clear, artistic." The men are described as "excelling in inner resources, loyal, responsible, colorful, sensitive, of rich imagination, and early maturity of judgment." But these men and women carry the burdens of "retreats into fantasy, marked insecurities, obsessiveness, sleep-walking, anxieties, snobbishness, intolerance, fears, hostilities, procrastinations." The examiners expect the constructive elements here to overcome the destructive ones, but the chances for success seem greater than the chances for happiness. It is interesting that 2 of the strongest of these students have already sought help in analysis.

IV. In the 3 groups already described the examiners felt that the balance was on the constructive side, but about this next group of 9 students they were doubtful. Again there is high intelligence in all, and in different individuals ability to work hard, idealism, frankness, and "a rich and gifted personality." But there are alarming liabilities: depressed and schizoid states, obsessions, coldness, sadism, "a precarious bizarre balance," conversion symptoms.

Personal Data

Students selected for one reason only—election to councils in small colleges where they were well known to their classmates—show great differences in almost every side of character. In neurotic manifestations they run the gamut. In their histories, from themselves and their parents, are there explanations for the presence of the neurotic traits?

Happy and unhappy marriages furnished individuals for all the groups, but in all the marriages there were only 3 in which the student did not receive warm affection from one parent—all 3 students show much neurosis.

A surprising amount of discipline was shown in the bringing up of students who have apparently very little neurotic disposition. The English plan of a governess and strict schedules has produced several well-balanced and constructive individuals. The strictest discipline was consistent and thoughtful: the child never got what he cried for, was allowed no likes or dislikes in food; but the parents allowed themselves no likes or dislikes in food: when he was 2 and another baby came, the father gave the first child a great deal of attention: the parents did not discipline the child for their own convenience.

Four children were "cured" of temper tantrums by being plunged into tubs of cold water: 2 have come out with severe and 2 with minor neurotic traits.

Feeding difficulties occurred in ½ of the children. Toilet training was completed in any time between 4 months and 3 years, with some enuresis going on to 16 years: no correlation in feeding and toilet training and later traits can be seen with our information. But in 1929 and 1930, when these students were infants, "the book" was Watson; "on the hour," "early toilet training," and other procedures were adopted by the mothers as the thing to do and perhaps not as an outgrowth of their own characters.

The parents of student A were openly in conflict and brought up their children harshly. The very intelligent student is now submissive but bitterly critical and insecure—his relationships to people as unsatisfactory now as they were in his infancy. He is a burnt child. He needs succor and support (oral). He has great ability.

Unhappy parents subjected student B to similar harsh discipline—toilet training was finished at 5 months. He has come out of this with an underlying fear of inadequacy but an ability to handle people well. He is gentle and altruistic, as if he wished for other people the love and harmony that he himself missed as a child.

Student C, with parents always critical and never warm, was a feeding problem, a rebel at school, and now is cold and depressed with extraordinary potential now in abeyance.

The sets of parents of students D and G were happy together with strict super-ego demands upon their children, toward whom they were cool. Student D is a very cold and introverted person, still in rebellion against his father. Student G is very cold, hostile, evasive.

Student E, torn by receiving affection from a mother for whom she had little respect and rebuffs from a father with whom she felt a deep bond, is schizoid.

From parents warm and unworldly, student F has become an idealist in a most precarious balance.

But two neurotic parents, one a perfectionist, had an only daughter H, who is steady, quiet, reserved, and integrated.

What Is a Normal Person?

Through this study of a college group an approach to a definition of normality is possible. Perhaps instead of *normality* we should say *mental health*. But *normal* is so often used by people that it deserves a clearer practical definition than it now has. There are some negative points.

Normal does not mean average. There is a use of the word *norm* in many sciences to mean the median of a large group. Thus in intelligence quotients, there is a norm between 90 and 100; but an I Q of 130 does not mean abnormality but a ranking 30-odd points above the median. However there is a demand for a normal person to fit into his society and that society is probably influenced more by average than by gifted people. Karl Menninger has said, probably to stir discussion, "Anyone who achieves

anything is *a priori* abnormal." But Benjamin Franklin, who achieved in many fields, is the personification of normality as he fitted into his place and time. The students in the present study achieved and remained normal.

Normal does not mean uninteresting. In a current play certain sophisticates are exemplified by a wife who, disturbed and bored because her husband is normal and faithful, sends him to a psychiatrist. In a current novel an author says that rationality is a token of a drab soul—the beautiful are the misfits. One can sympathize, in moderation, with the effort to find beauty in criminals; one cannot sympathize with the refusal to see beauty in the steady, kindly, hard-working, law-abiding citizens. They are condemned because they are conventional, which means that they have adopted customs that have been proved agreeable to other people. Many who are prejudiced against the normal are thinking, "I am a misfit, and so I must be interesting—perhaps a genius."

In the council study the students whose neuroses are overwhelmed by their abilities are as interesting as are the students in trouble. One young woman, "normal if anyone is normal," by the Rorschach interpretation "of fine, free, flexible mind, relaxed, of high intelligence, with no need to impress" is original, humorous, friendly, capable; in childhood she was raised "by the book," cured of thumb-sucking by a metal cap: she was mischievous, precocious, independent, daydreamed that she was illegitimate. Now with well-directed energy, none of it wasted, but with some concern about her body and looks, she plans to put some of her original ideas into practice. She is far from uninteresting.

And normal is not perfect, although many parents and teachers seem to think so. Perfection does not fit human nature. Neurotic, unreasonable thinking enters early into all people; although it sometimes can be used to make adult lives better, it still is there. It is useful to think of normality as a passing mark of 60% to 90%. Members of the student council are spread along this range.

A normal person is not one who has no problems. This is understood by psychiatrists and a few others. Anna Freud discusses the production of anxiety as a normal function of the ego, not a neurotic manifestation. General Omar Bradley writes, "Where there are people, there is pride and ambition, prejudice, and conflict. In Generals as in other men, capabilities cannot always hide weakness nor can talents hide faults."

But people in general still tend to think in terms of all or nothing: "I am 100% normal or I am crazy!" They approach panic when they discover some unreason in themselves. If people could get a better notion of how reason and unreason are mixed in everyone, they could live more confidently and get help more easily—that perhaps is one advantage of such a study as this.

If the public is thinking of normal as either drab and average or without conflict and perfect, it is time for psychiatrists to put forward more useful and constructive descriptions.

1. Normality has a wide range and is in a state of flux.

2. Normal people are free to focus their energies, their gifts large or small, on main purposes.

3. In their own culture normal people work and love with ease, happiness, and efficiency somewhat in proportion to their circumstances.

A description of people in mental health is given in a widely publicized statement of the National Association for Mental Health. "They feel comfortable about themselves [one hopes, not too comfortable]; they feel right about other people—they can like and trust others; they are able to meet the demands of life."

In one sense (Adlerian) the normal person is a harmless one, any destructive tendencies are under control. In another sense (Ernest Jones) the normal person is fearless, free of inappropriate anxiety.

What Is a Grown-Up Person?

Following is the answer of one student to the question, "What is a grown-up person?" It was given spontaneously, without hesitation.

Tolerance and understanding are important. Both are attained by an emotional security within which growth can take place. Many things can influence

this but if firmly laid down by adolescence it takes a great shock to upset them. Grappling with problems and thinking them through without blindly accepting them is necessary. A mature individual is a middle-line person who has integrity, can stand steadfastly and assuredly, can make compromises in a friendly way. He can adjust to mores and yet go against them if he feels it is terribly important. Also, he has to be dependent, but at the same time must have the ability to face himself and be alone with himself. I don't think a mature person ever grows old in that he always keeps possibilities open and never thinks he has the final answer on anything. Because of all these things, such a person is able to speak frankly, directly, and sincerely. He should be able to understand animals, children, and the like. If a person is really mature, he doesn't think of himself as such. He is humble, instead of seeing himself as superior to his fellow men, he sees himself as being only a very small part of a very large and important picture.

Normality can also be considered as emotional maturity, with the understanding that 21 is the conventional age at which grownup life should begin. Anyone putting down the characteristics of full emotional growth would put most importance on integration, the capacity for unselfish love, freedom from childish thinking and prejudice, and other points in harmony with the ideas about the normal on the preceding pages. And maturity again is a passing mark, covering a wide range.

This student council group, I think, justifies its being chosen for a study of normality. All of its members are succeeding in what should be a main purpose in their special culture—success in college. Over half of them are efficient, easy, happy. About a fourth are just as efficient, but with much more effort and not so much happiness—with more neurosis; these have great possibilities for success in all directions if they "pull themselves together." And the few who are in great trouble have great abilities which may swing the balance in the constructive direction.

And the students are examples of the wide range of the normal, from the splendidly organized group to those who are still struggling to find themselves. Are the 9 who have the deepest neurotic tendencies normal?

These 9 students are successful in college —they have mobilized their energies to that extent. No one of them has given up the struggle against hostility, depression, insecurity, coldness, splittings; in fact some have definitely improved in the 4 or 5 years since the examinations were made. How free they will be to love and work is a matter for the future. At the time they were examined they might be considered as balanced on the low edge of the normal.

DISCUSSION

A committee report of the Group for Advancement of Psychiatry[4] states that when psychiatric facilities are available 10% of the student body requests help for handicapping emotional problems. "While these requests should be met as far as possible, it is with the remaining 90% that the psychiatrist should be able to make significant contributions to emotional stability." A Committee report of a National Conference on Mental Health in Colleges[5] estimates that 15% of all college students should be expected to benefit from adequate mental hygiene services; 5% urgent cases, 5% with enough emotional discomfort to warrant treatment, 5% who could get along without help but find college easier with it.

In this study of 64 more successful than average students the examiners consider that 57% could be expected to benefit from ideal mental health services, 14% being urgent. Possibly all, and certainly most, of the whole 57% will manage their neurotic troubles, but at best a considerable number will love and work under handicaps. Through pride or through fear, those who need help most will not go to a psychiatrist. Curiously enough, the 2 students who after college have sought such help are two in the Group III who were considered to have great strength, which they have shown by seeking help.

One of the reports quoted above goes on to say: "Psychiatry deals . . . . with disordered emotional development and hence should be in a position to aid in the understanding and promotion of those factors in colleges which (a) encourage sound judgment, (b) free from crippling anxiety and prejudice, (c) bring sensitive appreciation of the needs and rights of others and (d) integrate character."

[4] Psychiatry in Higher Education, 1950.
[5] May 7-10, 1947.

The colleges are not responsible for the neurotic traits appearing in these students—that is clear from the histories. Some of the students who were examined in the first 2 years of college gained ground in the junior and senior years and were better balanced at graduation. Whether students who fail in college, academically or in the eyes of their fellows, are hurt in college is another matter.

Curiously, psychiatrists would know best what to do about the severest neuroses or psychoses; the number of psychiatrists equipped to help in the mildest and most delicate situations is small. Perhaps they should work most with the faculty, or wardens, or such student groups as the councils themselves. They should know how to let well enough alone. "Colleges of all places should be unusually tolerant of the unusual personality."

To publish the fact that so many gifted people have neurotic handicaps is in itself a way to make it easier for such persons to ask for help.

BIBLIOGRAPHY

1. Healy, William. Personality in Formation and Action, pp. 54-69. New York, W. W. Norton & Co., 1938.

2. Bond, Earl. The student council study: A preliminary report. Am. J. Psychiat., 107: 271, 1950.

PSYCHIATRIC AND PSYCHOLOGICAL INVESTIGATIONS OF CONVICTED SEX OFFENDERS: A SUMMARY REPORT[1]

RALPH BRANCALE, M.D., ALBERT ELLIS, PH.D., AND RUTH R. DOORBAR
Menlo Park, N. J.

This paper presents a summary of a series of studies of convicted sex offenders who have been psychologically and psychiatrically examined at the State of New Jersey Diagnostic Center(1-3). Under the New Jersey Sex Offender Act of 1949, all persons convicted of minor or major sex crimes in the state had to be sent to the Diagnostic Center for a thoroughgoing psychological-psychiatric testing and interviewing process, in order that those offenders who showed a definite pattern of repetitive and psychiatrically deviated behavior could be sent for treatment in a mental hospital rather than in a penal institution. Examinees were considered to be psychiatrically deviated when their sex offenses were specifically linked with some form of severe emotional disturbance or mental malfunctioning; when it appeared that they would very likely continue to commit further offenses because of their emotional disturbance or impairment; and when they gave indications of continuing to commit sex offenses in such a manner as to prove themselves to be real social menaces.

The results of examining the first 300 consecutive subjects under the New Jersey Sex Offender Act are herewith summarized. The sample employed in these studies represents an unbiased 100% sample, and is doubtlessly representative of sex offenders who are usually apprehended and convicted in New Jersey. The data to be presented were gathered by means of psychiatric social worker, psychological, and psychiatric interviews, and by means of psychometric and projective tests (including the Wechsler-Bellevue, Rorschach, and Figure Drawing tests in all instances, and various other projective techniques in some cases). These data were statistically analyzed, by means of correlational and other techniques, and were also analyzed from a clinical viewpoint, on the basis of qualitative evaluations of all the relevant data gathered on each individual offender. Psychiatric diagnoses and evaluations of the cases, as employed in both the statistical and the clinical analyses, were never made on the basis of one or two interviews, but were derived from the total interview, testing, and often sodium amytal interview material available for each offender examined. First some of the statistical and then some of the clinical findings will now be briefly summarized.

[1] The data employed in this study were gathered at the New Jersey State Diagnostic Center at Menlo Park. All statements and opinions in this paper are solely the responsibility of the authors and no responsibility for them is assumed by the Diagnostic Center or the New Jersey Department of Institutions and Agencies.

STATISTICAL FINDINGS

1. The majority of convicted sex offenders were found to be rather innocuous, inadequate, passive, and minor offenders rather than violent, sadistic "sex fiends." Such relatively minor offenses as statutory rape, mild sexual assault, verbal sex acts with minors, exhibitory acts, and dissemination of "obscene" materials accounted for 58% of the sex convictions studied; while major offenses like serious sexual assault, forcible rape, noncoital sex relations with a minor, and homosexual relations accounted for 42% of the convictions. These statistics are given in terms of the actual illegal sex acts performed by the offender, rather than in terms of the technical charge against him.

2. Only a small percentage of convicted sex offenders (21%) were found to use force or duress upon their victims.

3. Thirty percent of the convicted offenders were found to have been previously arrested for sex crimes. Fifty-four percent admitted committing previous sex offenses for which they may or may not have been apprehended. Thirty-one percent had been previously arrested for nonsexual crimes.

4. When the term "sexual psychopath" was rigorously and properly applied[2] to the

[2] See clinical finding 3, below.

convicted examinees who were psychiatrically and psychologically studied, it was found that only about 3% could be legitimately called "psychopaths." (Frankel's study (4) of New Jersey Sex Offenders found about 11% "psychopaths"; but his criteria were behavioral rather than psychiatric, and stressed repetitive antisocial behavior without inquiry into the psychodynamics of this behavior.)

5. Of the offenders examined, 14% were diagnosed as being psychologically "normal"; 29% were found to be mildly neurotic; 35% severely neurotic; 8% borderline psychotic; 2% psychotic, 5% organically brain-impaired; 3% psychopathic; and 4% mentally deficient. (Frankel(4) found a somewhat higher percentage of mentally deficient offenders, but employed purely psychometric criteria rather than considering, as did the present study, the total psychological-psychiatric picture of the individual offenders.)

6. Almost exactly half the convicted sex offenders were found to display pathological mechanisms and dynamisms contributing to their sexual behavior. In 27% of the cases, clear-cut evidence of psychiatric disorder directly responsible for compulsive or repetitive deviational behavior was found; and, under the provisions of the New Jersey Sex Offender Act, these individuals were committed to a state hospital for psychiatric treatment. (Included in this 27% were a few cases who were judged to be legally insane, and who were not actually committed under the provisions of the Sex Offender Act but under the provisions of the regular mental hygiene laws of the state.)

7. High rates of severely disturbed patterns of behavior were found in virtually every category of sex offender, with the notable exception of those convicted of statutory rape (only 16% of whom were found to be severely disturbed). Relatively high rates of disturbed behavior were found among those convicted of forcible rape and exhibitory acts; and relatively high rates of commitment for psychiatric deviation were recommended for offenders convicted of noncoital sex relations with a minor and of homosexual relations.

8. Fifty-four percent of the convicted sex offenders were found to be sexually inhibited and neurotically constricted rather than overimpulsive and oversexed. While low rates of sexual inhibition were found among those convicted of statutory rape and incestuous relations, 66% of those convicted of noncoital sex relations with a minor, 72% of those convicted of exhibitory acts, and 88% of those convicted of disseminating "obscene" materials were found to be sexually inhibited.

9. No clear relationship was shown between the seriousness of the sex offense and the seriousness of the offender's emotional disturbance. On the contrary, high rates of severe disturbance were found for "major" offenders, like those convicted of forcible rape and noncoital sex relations with a minor, and also for "minor" offenders, like those convicted of exhibitory acts.

10. Forty-five percent of the convicted offenders gave evidence of being severely emotionally deprived during their childhood; but a good many other offenders were also found to have had distinctly overaffectional ties to their parents during their childhood.

11. High rates of severe emotional immaturity were found among all types of convicted sex offenders examined, with 91% of the subjects proving to be distinctly emotionally immature.

12. Thirty percent of the offenders gave evidence of being basically hostile individuals. Underlying or overt hostility was particularly evident in those convicted of sexual assault, forcible rape, and incestuous relations and was relatively seldom found in those convicted of statutory rape and exhibitory acts.

13. Forty-five percent of the offenders displayed subnormal intelligence (as compared to an expectation of 25% in the American population); and 9% were found to have bright normal or superior intelligence (as compared to an expectation of 25% in the American population). Subnormal intelligence was particularly found in offenders convicted of statutory rape and incestuous relations; and was least frequent in those convicted of forcible rape, exhibitory acts, and disseminating "obscene" material.

14. Thirty-two percent of the offenders exhibited alcoholism as an associated or precipitating factor in their offenses. Alcoholism was most prevalent among offenders con-

victed of incestuous relations, sexual assault, and homosexual relations, and least prevalent among those convicted of statutory rape and disseminating "obscene" materials.

15. Offenders convicted of acts involving sexual deviation (including noncoital sex relations with minors, exhibitory acts, homosexual acts, and bestiality) were found to be significantly different from offenders convicted of nondeviational acts in that they tended to be older, to have histories of previous sex offenses, to have committed their offenses without extenuating circumstances, to display disturbed behavior, and to be thought to have a poor prognosis.

16. Negro offenders tended to be significantly different from white offenders in that they were less emotionally disturbed, less inhibited in their love lives, younger, better socially adjusted, and less likely to be involved in a deviational offense.

17. White offenders, particularly those convicted of a major sex offense or an offense involving sex deviation, tended not only to be generally emotionally disturbed but to have several interlocking neurotic traits—including feelings of inadequacy, anxiety, depression, and tension.

18. Convicted offenders who committed their offenses without extenuating circumstances (that is, when they were not under the influence of alcohol, not enticed by their sex "victims," nor otherwise encouraged in their acts) were found to be significantly different from those committing acts under extenuating circumstances, in that the former tended to be recidivists, to be sex deviants, to be severely disturbed, and to have a poor prognosis.

19. Offenders under 30 years of age tended to differ significantly from those over 30 years of age in that they were nonalcoholic, were convicted of nondeviational offenses, had committed their offenses under extenuating circumstances, were relatively free from emotional disturbances, and were deemed to have a favorable prognosis.

20. Offenders who, after psychological and psychiatric examination, were found to be committable to a mental institution for treatment were also found to be significantly older than noncommittable offenders, to have records of previous sex offenses, to have committed their offenses without extenuating circumstances, to lack insight, to be severely disturbed, and to be thought to have a poor prognosis.

Clinical Findings

1. Convicted sex offenders may be divided into 4 major groupings:

(A) *"Normal" sex offenders* may be said to be reasonably well-adjusted, or at least sexually nondisturbed, individuals who participate in sex acts, such as adultery or coitus with a somewhat underaged partner, which are legally impermissible but are not abnormal or pathological. "Normal" sex offenders may also include individuals who occasionally, particularly under the influence of alcohol, engage in "abnormal" or "perverted" sex acts (*e.g.*, homosexuality), but who do not habitually or exclusively derive satisfaction from such acts.

(B) *Sexually deviated but psychiatrically nondeviated offenders* may be said to be individuals who regularly or frequently engage in "abnormal" sex acts (*e.g.*, homosexuality or sex acts with children), but who remain sufficiently well-integrated and emotionally stable to pursue their aberrant behavior without getting into trouble with society or themselves.

(C) *Sexually deviated and psychiatrically deviated offenders* may be said to be individuals who engage in "abnormal" acts (*e.g.*, exhibitionism) and who do so in a repetitive, compulsive, or otherwise emotionally disturbed manner, and who usually keep getting into difficulties because of their nonintegrative sex behavior.

(D) *Sexually nondeviated but psychiatrically deviated offenders* may be said to be individuals who engage in "normal" sex acts but who do so in bizarre and nonintegrative ways that are socially repulsive, and that sooner or later get them into official difficulties; or they may be individuals who engage in "abnormal" sex acts as a by-product of their general disturbance rather than because of any specific sex disturbance. Thus, psychotic or brain-damaged persons who masturbate in public or walk naked in the streets may be psychiatrically but not necessarily sexually disturbed.

2. Most convicted sex offenders fall in the "normal" grouping; a sizable proportion fall in the sexually and psychiatrically de-

viated grouping; and a small proportion fall in the sexually nondeviated but psychiatrically deviated grouping. Most sex offenders who are *not* convicted, or who rarely get into official difficulties, fall either in the "normal" group or in the sexually deviated but psychiatrically nondeviated group. These individuals, being sufficiently well-integrated, may continue to commit offenses like fornication, homosexuality, adultery, or peeping without being apprehended and convicted; and even when they occasionally are apprehended, they do not present serious psychiatric problems.

3. The term "sexual psychopath" is a particularly inappropriate one, which is usually inaccurately employed, and which should not be confused with the term "psychiatrically deviated offender." A so-called psychopath, from a clinical standpoint, tends to react to *many* phases of social conduct with unbridled, primitive aggression and immature drive; to be affectless or without sense of guilt about his antisocial acts; and to be relatively ego-integrated in his self-centered, impulsive, and reckless behavior. A psychiatrically deviated sex offender, however, often is a severely neurotic or borderline-psychotic individual who is intensely insecure and nonintegrated, who has never gained any appreciable amount of poise, social courage, or emotional stability, and who tends to be seriously disturbed not only in his sex development but in virtually all aspects of his personality. Sexually and psychiatrically deviated offenders include a small proportion of so-called "psychopaths," a much larger proportion of neurotics, and a sizable proportion of borderline psychotics, psychotics, and brain-damaged individuals.

4. Two important types of convicted sex offenders may be termed the compulsive neurotic and the schizoid or borderline-psychotic type. The compulsive neurotic is frequently an extremely inhibited person who, now and then, is forced or compelled to react against his own inhibitions and to behave in what seems to be an *im*pulsive but actually is a *com*pulsive manner. He abnormally explodes, from time to time, because he abnormally holds himself in most of the time. The schizoid or borderline-psychotic sex offender may normally hold himself in sexually (and otherwise) but eventually displays outbursts of sexuality that take on an unrealistic, bizarre, and sometimes cataclysmic pattern of behavior that may be so irrational as to appear almost without motive. While the compulsive neurotic's explosion of sexuality will usually be of a physically harmless nature—*e.g.*, homosexuality or exhibitionism—the near-psychotic's outbursts may be so unpredictable, intense, and bizarre as to lead to physically violent sex acts (*e.g.*, homicidal rape).

5. Convicted sex offenders as a whole tend to be considerably more neurotic than "psychopathic." Convicted offenders who are actually sent to prison, however, tend to include higher percentages of so-called psychopaths, since incarcerated offenders more frequently have records of nonsexual as well as sexual offenses and are more generally antisocial in their behavior. For this reason it is dangerous to try to determine the personality characteristics of convicted sex offenders by studying prison populations alone. The social hostility of nonimprisoned offenders is likely to be a deeply repressed hostility that overtly takes the form of obsessive-compulsive urges; and these compulsions, in fact, help defend this type of individual *against* his overtly expressing his hostilities in more direct forms. Consequently, the compulsive neurotic's sex offenses will commonly take relatively nonaggressive directions (*e.g.*, exhibitionism) while the so-called psychopath will more frankly show his hostilities in violent sexual (and nonsexual) acts, for which he is more likely to be given a state prison sentence after conviction rather than probation or a short stay in the county jail.

6. Sex offender acts, such as the recent New Jersey acts requiring the psychological-psychiatric examination of all convicted offenders, are valuable for several reasons: (A) They offer a method for discovering many offenders who are so seriously disturbed as to be beyond salvage by regular penal treatment and who should be afforded psychiatric treatment in a suitable institution. (B) They provide means for detecting relatively mildly disturbed offenders who need not be incarcerated but may be treated successfully in the community. (C) They give formal recognition to the fact that many sex offenders are disturbed rather than vicious individuals; that compulsive and fixed sexual

deviation is a psychiatric classification rather than merely a penal offense; and that psychiatric and psychological decisions concerning offenders should be placed in the hands of competent professional workers who have adequate diagnostic facilities at their disposal and are not prejudiced by purely punitive philosophies. (D) They provide for invaluable consultative aid to courts, probation departments, and other law enforcement agencies, which without this aid cannot comfortably handle sex offenders. (E) They provide an entering wedge for the ultimate psychiatric and psychological examination, after conviction but before sentence, of *all* offenders, nonsexual as well as sexual. (F) They make possible adequate researches into the personality makeup and psychosocial backgrounds of sex offenders, so that vital knowledge may be gained regarding the prevention of sex offenses and the effective treatment of sex offenders.

7. Experience at the Diagnostic Center has shown that all sex offenders, "minor" as well as "major," should be psychiatrically examined after conviction but before sentencing. This is because the seriousness of an individual's sex offense may by no means be closely correlated with the seriousness of his emotional disturbance, nor with his potential dangerousness; and "minor" offenders, such as exhibitionists, are often precisely the ones who, if promptly examined, may be most amenable to psychotherapeutic treatment and rehabilitation. Moreover, current legal terminology in regard to sex offenses is so confused that it is almost impossible to distinguish, in written statutes, between "minor" and "major" offenses.

8. There should, at the present time, be no fixed or overspecific rules for designating sex offenders as psychiatric deviates. The 3 main criteria suggested by the Group for the Advancement of Psychiatry—namely, repetitive compulsive acts, forced relations, and age disparity—are important guideposts, but must be unrigidly interpreted in the light of the findings of each individual case. There is no one cause nor one effect of psychiatrically deviated sexuality; but, instead, different offenders exhibit emotionally fixated, compulsive, and aberrated sex behavior for a variety of reasons, and with a number of different behavioral results. Moreover, in designating an offender as psychiatrically deviated it may be much more important to predict what he *may do* rather than to judge him on the basis of what he *has done*. The writers would suggest these 3 main criteria for terming a sex offender psychiatrically deviated, and would urge open-minded application of these criteria in each individual case: (a) when it would appear that the offender is neurotic, borderline psychotic, psychotic, brain-impaired, psychopathic, or mentally deficient in such a manner that his sex offense may be specifically linked with his emotional disturbance or mental malfunctioning; (b) when it would seem that, unless and until he receives some form of therapeutic aid or custody, the offender will very likely continue to commit further offenses because of his emotional disturbance or impairment; (c) when it would appear that the offender will not merely commit sex acts that are technically banned, but will commit them in such a manner as to prove himself to be a real social menace.

9. When properly designated by a psychiatrist-psychologist-social worker team as a psychiatrically deviated sex offender, a convicted individual should, if possible, be returned to his community, placed on probation, and given outpatient psychiatric treatment. If he is sufficiently disturbed or is likely to commit other sex offenses with serious social implications, he should be placed in a suitable mental institution for treatment and held there, without any minimum or maximum sentence, until the staff of the institution feels that it is safe for him to return to the community. Sex offenders who are found not to be psychiatrically deviated should be returned to the court for ordinary prison sentence, but with recommendations (which may not be binding on the court) by the examining psychiatric-psychologist-social worker team.

BIBLIOGRAPHY

1. Ellis, Albert. A study of 300 sex offenders. Internat. J. Sexol., 4: 129, 1951.

2. Ellis, Albert, and Brancale, Ralph. The psychology of sex offenders. In manuscript.

3. Ellis, Albert, et al. Characteristics of convicted sex offenders. J. Soc. Psychol. (in press).

4. Frankel, Emil. Psychiatric Characteristics of Sex Offenders. Trenton, N. J.: State Department of Institutions and Agencies, 1950.

PSYCHOSIS DURING ELECTROSHOCK THERAPY: ITS RELATION TO THE THEORY OF SHOCK THERAPY [1]

EDWIN A. WEINSTEIN, M.D., LOUIS LINN, M.D.,
AND
ROBERT L. KAHN, M.A.
New York, N. Y.

The appearance of psychotic symptoms as a consequence of electroshock therapy (ECT) is a common occurrence (1-7) among patients who have been intensively treated. In addition to the memory impairment that is constantly present, there are other alterations of behavior that were not present prior to the administration of ECT. These include various degrees of excitement, paranoid delusions, euphoria, and hallucinations. The present case is being reported because it was found that the psychotic symptoms were not simply haphazard complications of treatment but that they formed an orderly pattern of behavior that could be correlated with other evidence of alterations in brain function. These relationships appear to have a significant bearing on the therapeutic action of ECT.

A. R., a 48-year-old housewife, was admitted to the neurological service of the Mount Sinai Hospital on April 28, 1950, because of pain and progressive weakness in her legs. On May 5 a hemangioma was removed from the spinal cord at the T8 level. As she did not improve following this procedure, a second laminectomy was performed on June 27 and an extensive arachnoiditis reported. After this operation the patient developed a complete paraplegia in flexion with severe deformity. There was marked diminution of all sensory modalities below the T8 dermatome and she had urinary and fecal retention. She complained of increasingly severe pain in her legs unrelieved by codeine, demerol, and methadone. The patient was depressed, bitter, and irritable, would scream in agonized fashion, and would reproach the staff for not responding more sympathetically to her.

Behavior Accompanying First Course of ECT

On October 1, 1950, a course of ECT using the Reiter apparatus [2] was begun in an effort to control her pain. She was given 3 treatments on consecutive days. Several hours after the second treatment she seemed more hostile and suspicious toward the nurses than heretofore and refused to let them touch her legs. She asked, "What happened to my legs; they are bent . . . . they were never that way before." She repeatedly asked if she had just awakened from a dream. The expressed feeling of unfamiliarity with her surroundings was striking. Following the third treatment the patient became affable, no longer complained of pain, and in an interview on October 4 denied having any pain even on direct questioning. When she was asked why she was in the hospital she replied, "My feet won't walk." She remarked on "how nice everyone is to me" and joked with the staff. She was disoriented for place, naming the hospital correctly but placing it in another part of the city. She was also disoriented for date naming the month as September or April. She believed that she had been in the hospital only 2 months. On several occasions she was disoriented for the time of day. In naming objects she made paraphasic errors, such as calling a tongue blade a ruler. An EEG performed on October 6 showed diffuse delta activity at a frequency of 3 to 6 per second.

The state of affability lasted for 3 days during which no further shocks were given. She then began to complain of pain again, reproaching the nurses in a querulous fashion. She was only slightly disoriented for time and place and showed no paraphasia. She was given an injection of 4 grains of amobarbital sodium and while under the influence of the drug she denied pain in her legs and complained of pain only in her arm, at the site of the injection. She also became more markedly disoriented for time and place.

Behavior Accompanying Second Course of ECT

On October 9 shock treatments were resumed and she was given 9 convulsions on consecutive days. At the end of the series she was again euphoric and did not complain of pain even though she was observed to wince when turning in bed. When catheterized she moaned as if in pain but joked with the doctor. She now showed a reduplicative disorientation for place, or reduplicative paramnesia; that is, she named the hospital correctly and located it within a few blocks of the actual site. She claimed, however, that she had come from "another Mount Sinai Hospital" situated nearby. She stated that each hospital had the same

[1] From the Neurology and Psychiatry Services of the Mount Sinai Hospital, New York. Aided by the Neurological Research Fund.

[2] A Reiter Electrostimulator, Model CW 46 was used, with a fluctuating unidirectional current and electrodes placed on both temples.

doctors and nurses but that in the "other Mount Sinai Hospital" the nurses had been very inconsiderate. "You could yell your guts out and get nowhere." In the present hospital, however, the nurses were described as "kind and wonderful."

Perception was further tested by the application of 2 simultaneous cutaneous stimuli in sentient areas above the level of the lesion(8). When a single stimulus was applied the patient perceived it accurately. When the examiner's fingers were applied to her cheek and to either hand she reported either only the face stimulus or displaced the hand stimulus to the other cheek. Prior to the administration of ECT she had been able to localize 2 simultaneous stimuli accurately in all dermatomes above the level of the lesion.

Behavior Following Cessation of Second Course of *ECT*

The state of elation lasted for 2 days during which time no further treatments were given. She then became acutely disturbed. When a nurse approached her, the patient attacked her and tried to scratch her. When a male orderly intervened, she shouted, "Don't, Bill, you are committing a felony." Speech was jerky, echolalia was present, and there was flight of ideas and distractibility. When asked whether she had seen the examiner before, she answered, "Yes, on death's stoop." When asked where she was she replied, "We're not in Heaven, we're not in Hell, we're in a victorious city." She resisted being put back in bed, protesting that it was not hers but "a bed for cripples." She denied that she had ever been ill, or that she had ever had any pain or operations. She misidentified people and misnamed objects identifying one examiner as "Jack," another as "Robert," and thought that a female patient whose head had been shaven recently was her son. She called a glass drinking straw a "pipe for smoking." In this stage she had fecal incontinence for the first time.

During the next few days the hyperactivity receded and the paranoid features were more prominent. She refused medication for fear she would be poisoned. When an examiner moved her leg she asked, "What are you trying to do, place it back on me?" While her catheter was being changed she asked if she were having a miscarriage. Various other stimuli were also interpreted in delusional fashion. She did not complain of pain but had attacks of panic that came in spasms. She would grip the side rail of the bed in terror and cry out, "What's the matter, I feel as if I am falling apart! That's what they want me to think." Although she made no mention of pain, the spasmodic way in which these panic attacks affected her suggested that they coincided with attacks of pain. This acutely psychotic stage lasted for one week and on October 23 the patient appeared rational and again complained of pain. She was well oriented and named objects correctly and interpreted her experience as a bad dream. She explained that she had thought that the room opposite her (patients' sitting room) was a whorehouse and that the nurses were trying to kill her. She thought that the side rails on her bed had grown thinner and this was a sign that she was going to die. She also said that she believed that the trouble with her legs had occurred because she had allowed a friend to perform cunnilingus on her.

Behavior During Third Course of ECT

During the next 3 weeks she became increasingly anxious and complained of a great deal of pain. She remained completely oriented and EEG showed only a small degree of abnormality. Amobarbital sodium given intravenously produced only a slight transient disorientation with no denial of pain. She was depressed, cried and pleaded for injections to make her sleep. On November 15, a third course of ECT was begun. The patient developed much the same picture that she had shown previously. On November 30, after the 11th treatment, she was euphoric and complained only spasmodically of pain. She again showed a reduplicative disorientation for place, stating that she was in a hospital near her home, to which she referred as the "younger Mount Sinai." She was also disoriented for time of day, gave paraphasic naming responses as calling a hypodermic needle a "tiepin." On double simultaneous stimulation, with her arms in a crossed position, one stimulus would be displaced. She claimed that her foot, which in its flexion deformity rested on her thigh, was the examiner's hand. She demanded that it be taken away but, although she kept complaining, began to joke about it and remarked that if the hand were not removed she would lose her virginity and would have to redivorce her husband.

Behavior Following Cessation of Third Course of ECT

The euphoric period was a brief one, lasting only a few hours, and the patient again became agitated and paranoid. She said that her legs had been pasted together by the examiner's brother. Another shock treatment was given and the next day she was again affable. However, on the same day she became agitated, complained of pain, and expressed a fear of dying. She thought the nurses were trying to poison her and telephoned the police to save her. She begged repeatedly to be put to sleep. She expressed the idea that her deformed legs were a kind of animal in her bed with her and asked, "Why do I have two assholes?" referring to a bedsore that had developed. On December 8 she broke a candy jar and, after threatening to slash a nurse, tried to cut her own wrist with a fragment. She was then transferred to a psychiatric hospital.

Seen on December 18, she was rational, clearly oriented, showed no perceptual alterations, and complained of severe pain. She explained that she had gotten the idea that, while smoking in bed, she had burned down the "old Mount Sinai Hospital" with the patients and that she was being killed for this in the "new Mount Sinai." Although she now knew that this was not true she asked to be reassured that she hadn't burned down the hospital.

When asked why she had tried to kill herself she answered, "I didn't want to kill myself. All I wanted to do was to go to sleep. I thought I could do this by pulling blood out of a vein and counting, just like when the doctors did it to me." The patient apparently was referring to the injections of sodium pentothal that were given prior to each shock treatment.

Premorbid Personality

The patient was described by her relatives as being an impulsive and excitable person who usually was good natured but who had a quick temper. She was energetic in a restless way and kept house in a slipshod manner. She had always been frightened of illness, pain, and hospitals, but was not a complainer. In the present illness she seemed to get temporary relief from pain by screaming and yelling. She was extremely sympathetic and generous to people who were ill or in trouble and would be hurt if others did not respond similarly to her. She would try to cover up this sensitivity, however, by appearing "hard" and flippant. She had been bitter that friends had not visited her in the hospital and, when they did come, she berated them severely, then carried on with the visit in friendly fashion. She was stubborn and headstrong and, if she did not get her own way, was likely to have a tantrum. She was not an openly warm and affectionate person but made friends easily and liked company. She had married at 19, had 4 children, and was divorced at 33 after she had become involved with "fast company." Following the divorce she drank heavily for a while "to forget her troubles" but liquor generally made her "feel sorry for herself."

DISCUSSION

Relation between Behavior and Level of Brain Function

The patient's behavior can be divided into 4 phases: (1) depressive reaction, (2) paranoid reaction, (3) euphoric reaction, and (4) panic or delirioid reaction.

In each state a relationship could be demonstrated between the patient's attitude toward her pain and illness, on the one hand, and other alterations in brain function on the other. These alterations in function were manifested by changes in orientation, language, perception, and the EEG rhythm. During the stage in which the patient was euphoric she completely denied her pain and illness, showed no overt anxiety, and manifested the greatest alterations in function. She was disoriented for place and time, misnamed objects, perceived correctly only one of two simultaneously applied tactile stimuli, and had a markedly diffusely abnormal EEG record. In the stage when the patient was depressed, she complained of severe pain. Here she was completely oriented, showed no alterations in perception and language, and the EEG was only slightly abnormal. Intermediate between the depressed and euphoric states there was a period in which there was a partial denial of the pain and incapacity associated with a lesser alteration of brain function than was shown in the euphoric stage. At this time the patient was paranoid. She blamed others for her pain and deformity, exhibiting little apparent anxiety. The transitions from the stage of greatest alteration of function to the stages of less alteration, *i.e.*, the paranoid and depressed, were marked by great agitation, the patient presenting the picture of a delirium. It was thus possible to see in this one patient all the various forms of the organic psychotic syndromes described as occurring during ECT(1). They are not different psychoses that appear now in one patient, now in another, but are phases of behavior correlated with the alterations of function initiated by ECT.

The depressive, paranoid, and euphoric states all centered about the patient's attitude toward her painful crippling disease. At each level of brain function there was demonstrated a mechanism for coping with this tremendous problem. Prior to the convulsive treatments, when no alteration in brain function could be demonstrated by the methods employed, she was depressed and anxious. She tried, in her interpersonal relations, to gain relief by complaining, getting sympathy, and expressing hostility to her family and the staff. At this time she showed no denial of the reality of her illness. After the administration of the ECT had produced the changes in brain function described, a new method of dealing with the pain and deformity appeared. This involved not the use of interpersonal relations, but denial. The patient exhibited no anxiety and seemed to solve her problem by denying its existence or blaming it on someone else. The delusion of denial or unawareness of physical defects (anosognosia) appears frequently in organic brain disease(9) and is accompanied by the type of changes in behavior, perception, and

the EEG record that were present in this case. Thus patients with hemiplegia, blindness, impotence, and incontinence become euphoric or paranoid and deny the existence of these defects.

Psychosis as a Withdrawal Reaction

In many of the recorded cases of psychosis precipitated by ECT, the acutely psychotic behavior is reported as appearing following the cessation of the shock administration. It appears to be analagous to the withdrawal syndrome that appears in addicts who are abruptly deprived of drugs. Similar behavior can also be seen in some patients with organic brain disease and anosognosia when the evidences of alteration of brain function are disappearing. The "withdrawal syndrome" seen in our patient is comparable particularly to the behavior that has been described in chronic barbiturate intoxication (10, 11). During the period of drug ingestion patients show depressed, paranoid, and euphoric attitudes and deny the existence of such symptoms as ataxic gait and urinary incontinence. After the abrupt withdrawal of barbiturates an acute hallucinatory delusional delirium appears. Our patient also showed a phenomenon comparable to the building up of tolerance to drugs. In the first course of ECT a euphoric state was reached after 3 shocks, while in the second and third series a successively great number of shocks was necessary for the production of the euphoria and complete denial. It is likely that the "withdrawal psychosis" does not represent any specific toxic or electrical effect but is rather the expression of a general principle of brain function. When a level of brain function is suddenly altered by removal of the maintaining chemical or mechanical agents, or even in the rapid removal or healing of a pathological disease process, there is a period of disorganization before the more highly integrated level can be established. During this period in our patient there appeared to be a desperate effort to maintain denial, which failed because the conditions of brain function were no longer available for the development of anosognosia.

The drive to deny illness is not caused by brain disease but it is a quality that is present in all persons. A study of patients with anosognosia (1) has shown that the denial does not depend only on the presence of altered brain function but is closely related to the person's character structure. Thus the anosognosic delusion was noted most prominently, and endured longest, in people who had always demonstrated a capacity to deny or seem unaware of their faults and felt inadequacies. These qualities were seen most conspicuously among obsessive personalities who, by the "magical" use of symbols as words and rituals and by their ability to place things out of awareness, could make a situation appear as they wanted it to be. They were people who had always regarded illness as a kind of imperfection to which they reacted with guilt or shame. In A. R.'s background these obsessive qualities were not conspicuous, and it is significant that the state of euphoria and complete denial that could be maintained was a brief one.

Theory of Therapeutic Action of ECT

A theory of the therapeutic action of electric shock is suggested by these observations. In the so-called functional depressions the action of the electric shock is to initiate the production of a state of altered brain function, in which the patient can deny his problems. Many people by reason of a characterologically determined capacity for denial may ward off a depression for years (13). When some circumstance interferes with the efficiency of this mechanism, the underlying depression emerges. However, in the altered milieu of brain function produced by ECT, the denial can again be established. As in some cases of organic brain disease (14), the denial may persist in characterologically disposed people long after the other signs of the organic syndrome can no longer be elicited. Accordingly, any agent that produces a prolonged alteration in function, of the type described, should be capable of altering a depression in a patient who characterologically solves his problem by denial. Thus, not only ECT, but prefrontal lobotomy (15), self-inflicted gun shot wounds (16), prolonged sedation (17), and metrazol (18) have all been successful in interrupting depressions. It likewise accounts for the fact that

in patients who maintain their adjustment by defenses other than denial, *i.e.*, people with hypochondriasis, conversion hysteria, and psychopathic behavior, ECT is not effective(19). It would also explain why ECT is of no value in giving the patient insight into his problems and preventing subsequent depressive episodes(20).

SUMMARY

1. A case of psychosis developing during 3 courses of ECT for relief of intractable pain is described.

2. The patient's attitude toward her pain could be correlated with other alterations of behavior as disorientation, paraphasic language, and changes in perception and the EEG record.

3. In the stage of greatest alteration of function, the patient was euphoric and denied her pain; with a lesser alteration of function she was paranoid and showed a partial denial, while with the least alteration of function she was depressed and completely aware of pain.

4. The acutely psychotic behavior that occurred following the cessation of convulsions is compared to the withdrawal syndrome that occurs when drug administration is abruptly stopped.

5. The concept of anosognosia is stated. It is suggested that the therapeutic efficacy of ECT in functional depressions derives from the production of a state of brain function in which the mechanism of denial is facilitated in characterologically disposed individuals.

BIBLIOGRAPHY

1. Kalinowsky, L. B. Organic psychotic syndromes occurring during electric convulsive therapy. Arch. Neurol. & Psychiat., **53**: 269, April 1945.

2. Frosch, J., and Impastato, D. Effects of shock treatment on ego. Psychoanal. Quart., **17**: 226, April 1948.

3. Frosch, J., et al. Intensive electroshock treatment with Reiter apparatus. Am. J. Psychiat., **108**: 204, Sept. 1951.

4. Tyler, E. A., and Lowenbach, H. Polydiurnal electric shock treatment in mental disorders. North Carolina M. J., **8**: 577, Sept. 1947.

5. Kerman, E. F. Electroshock therapy with special reference to relapses and effort to prevent them. J. Nerv. & Ment. Dis., **102**: 231, Sept. 1945.

6. Valentine, M. Intensive electroplexy. J. Nerv. & Ment. Dis., **109**: 95, Feb. 1949.

7. Frosch, J., et al. Some reactions seen after electric shock treatment. Am. J. Psychiat., **102**: 311, Nov. 1945.

8. Bender, M. B., et al. Patterns in perception on simultaneous tests of face and hand. Arch. Neurol. & Psychiat., **66**: 355, Sept. 1951.

9. Weinstein, E. A., and Kahn, R. L. Syndrome of anosognosia. Arch. Neurol. & Psychiat., **64**: 772, Dec. 1950.

10. Isbell, G., et al. Chronic barbiturate intoxication; An experimental study. Arch. Neurol. & Psychiat., **64**: 1, July 1950.

11. Wikler, A. Personal communication.

12. Weinstein, E. A., and Kahn, R. L. Personality factors in patients with anosognosia. (In preparation.)

13. Lewin, B. Psychoanalysis of Elation. New York: W. W. Norton & Co., 1950.

14. Weinstein, E. A., and Kahn, R. L. Patterns of disorientation in organic brain disease. J. Neuropathol. & Clin. Neurol., **1**: 214, July 1951.

15. Freeman, W., and Watts, J. W. Psychosurgery. Baltimore: Charles C. Thomas, 1942.

16. Guttmann, E. Suicidal head injuries. J. Ment. Sci., **89**: 85, Jan. 1943.

17. Klaesi, J. Ueber die therapeutische Anwendung der "Dauernarkose" mittels Somnifens bei Schizophrenen. Ztschr. f. d. ges. Neurol. u. Psychiat., **74**: 557, 1922.

18. Ziskind, E. Memory defects during metrazol therapy. Arch. Neurol. & Psychiat., **45**: 223, Feb. 1941.

19. Kalinowsky, L. B., et al. Electric convulsive therapy of psychoneuroses. Arch. Neurol. & Psychiat., **52**: 498, Dec. 1944.

20. Kalinowsky, L. B., and Hoch, P. H. Shock Treatments and Other Somatic Procedures in Psychiatry. New York: Grune & Stratton, 1946.

CHANGES IN BLOOD FLOW, BLOOD PRESSURE AND CARDIAC RATE ASSOCIATED WITH ELECTROCONVULSIVE SHOCK [1]

MARJORIE L. BROWN, M. S., GEORGE W. BROWN, M. S., H. M. HINES, PH. D.
Iowa City, Iowa

Although the mode of action of electroconvulsive therapy (ECT) is still unknown (1), various postulations have been made as to the mechanisms operating to effect psychological changes of a beneficial nature (2, 3). Many investigators (4-10) have suggested that electroshock produces cerebral anemia, and to this effect some workers have ascribed the therapeutic benefits of ECT that have been reported. Opposing this view, other workers have shown at least a focal increase in cerebral blood flow resulting from electric stimulation (12-16).

The present inquiry was stimulated by the existent controversy pertaining to the effects of electroconvulsive shock on cerebral blood flow. This investigation determined the concurrent physiological effects of electrically induced convulsions upon carotid blood flow, arterial blood pressure, and cardiac rate in dogs, using a newly developed blood-flow measuring apparatus.

MATERIAL AND METHODS

Blood flow was recorded in the common carotid artery of 16 dogs by means of the Electromagnetic Flow Meter (17). Direct arterial pressure measurements were made in the femoral artery employing a Statham Gage-Brush Recorder system. All surgical operations were carried out under general ether and/or local procaine anesthesia. When ether anesthesia was used, the animals were allowed to recover completely from the effects of the anesthetic before the electroshock stimulus was applied. No difference in the cardiovascular responses to electroconvulsive shock (ECS) was observed in the animals as a result of varying the anesthetic procedure. Intravenous Heparin (5 mg. per kg. of body weight) was administered to each animal to prevent blood clotting.

The voltage, current, and duration of the stimulus were recorded directly on a 2-channel Brush Recorder adapted to function as a recording voltmeter and milliameter. The duration of the stimulus could be calculated from the 60-cycle-per-second wave pattern recorded. The apparatus used to deliver the electroshock consisted of an isolation transformer, an electronic timer, a Voltrol voltage regulator, and 2 small electrodes. The source of the current was 115 volts, 60-cycle AC house current.

A shock setting was desired that would unfailingly produce a major convulsion upon the first trial; it is possible that the shock delivered to any animal was in excess of the minimum capable of inducing a major convulsion.

Recording of blood flow and blood pressure was continuous prior to, during, and after the electroshock stimulus was applied. Each animal was used as its own control with reference to blood flow, arterial pressure, and cardiac rate measurements. All changes in these entities are reported as percent variation from values obtained during a 10-minute steady state preceding the application of the shock stimulus.

A double vagotomy was performed on one animal in order to determine the mechanics of one of the observed cardiac responses to ECS.

Eleven female and 5 male dogs were used in the experimental series. Weights of the animals ranged from 5.7 to 15.5 kg; the mean weight was 8.5 kg. The various components of the shock stimulus recorded for the 16 animals were as follows: milliamperes ranged from 340 to 547, with a mean of 458 ma; volts ranged from 68 to 111, with a mean of 88 volts; shock duration was held constant at 0.2 second.

A major convulsion and respiratory arrest was produced in each animal immediately following the onset of the shock stimulus.

[1] Read at the autumn meeting of the American Physiological Society, Salt Lake City, Utah, September 6-8, 1951.

From the Department of Physiology, Medical Laboratories, State University of Iowa, Iowa City, Ia.

The duration of the convulsions ranged from 18 to 64 seconds, with a mean of 33 seconds; the length of the respiratory arrest ranged from 15 to 32 seconds, with a mean of 25 seconds.

Results

The mean control blood flow for the series of 16 dogs was 70 cc/min., with a range of 45-100 cc/min. The mean control systolic pressure was 188 mm. Hg., with a range of 125-272 mm. Hg. The mean diastolic pressure was 104 mm. Hg., with a range of 55-145 mm. Hg. The mean cardiac rate was 164 beats/min., with a range of 105-225/min.

The statistically significant changes in mean carotid blood flow after the onset of ECS exhibited the following pattern. During the first second postshock, there was an immediate decrease in mean blood flow of 51% below control level; this was followed by an increase in mean flow that reached a peak of 139% above control level by 21 seconds postshock. At 27 seconds postshock, even though the convulsions continued, the mean blood flow through the carotid artery decreased to 122% above control flow. Respiration was resumed during this time interval. Mean blood flow continued in a gradual decline after the cessation of the mean convulsion at 33 seconds postshock, returning to control levels by about 10 minutes postshock. Figure 1 shows the above changes.

In general, the arterial pressure changes and the cardiac rate responses following ECS present subdued replicas of the blood flow changes.

Immediately after the onset of ECS, the mean systemic blood pressure of the 16 animals showed a decrement of 30% below control levels. Thereafter, the mean systolic and diastolic pressures increased gradually to peak values of 53% and 35%, respectively, above control levels by 21 seconds postshock; this was the same time interval in which the mean blood flow peak was reached. At 27 seconds postshock, while the convulsions persisted and respiration had been resumed, the mean systolic and diastolic pressures decreased to 42% and 22%, respectively, above control levels. The decrease in pressures continued at a somewhat slower rate after the cessation of the mean convulsion at 33 seconds postshock. Mean arterial pressures returned to control levels at about 5 minutes postshock.

The mean cardiac rate decreased 36% below control levels in the first second following the onset of ECS; this was followed by an increase in mean cardiac rate that reached a peak value of 37% above control levels by 33 seconds postshock. This latter time coincided with the end of the mean convulsion duration. The peak value was

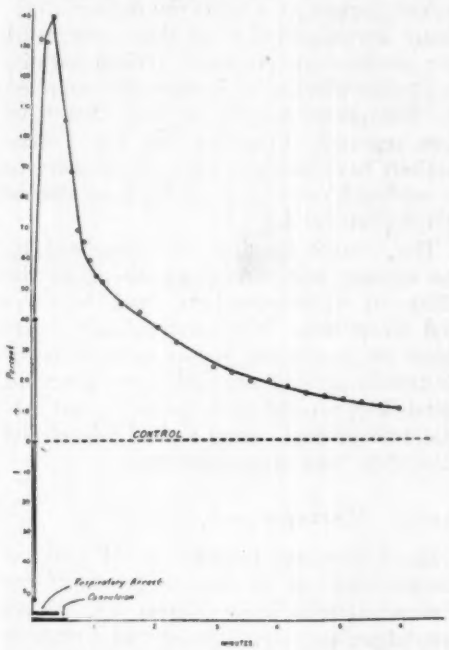


Fig. 1.—The mean percent deviations from control levels in blood flow following electroshock stimulation, for a series of 16 experiments on dogs.

maintained for 18 seconds after which the mean rate began a gradual and irregular decline toward control levels. Mean cardiac rate returned to control levels by about 5 minutes postshock.

One animal manifested a cardiac inhibition that began at the end of his convulsion (30 seconds) and lasted for 7 seconds. The duration of the current flow was 0.2 second; the milliamperage and voltage were 426 and 105, respectively. Another animal died 2 hours after shock. Examination revealed a profuse abdominal hemorrhage, the source of which was undetermined. The severity of the hemorrhage was probably due to the heparin-

ized condition of the animal. The current flow was 0.2 second; the ma and volts were 390 and 88, respectively; the duration of both the convulsion and respiratory arrest was 23 seconds.

In a preliminary study, it was found that shocks of long duration (1.0 to 2.0 seconds) produced cardiac inhibition in every instance, the inhibition ranging from 3 to 17 seconds in duration. The ma and volts were within the same range as for the 0.2-second shocks. An animal was administered a 2-second shock that produced cardiac inhibition for 3 seconds following the initiation of the shock stimulus. After the animal had returned to his control rate, a double vagotomy was performed and a shock stimulus of 2 seconds was again applied. A marked and prolonged increase in blood flow and arterial pressure occurred and a marked elevation in cardiac rate followed the onset of the ECS; no cardiac slowing or inhibition was induced.

Discussion

Kety and his associates(10), using the nitrous oxide technique on schizophrenic patients, report a marked decrease in cerebral blood flow after ECT; at the same time, the mean arterial pressures showed no significant change from the preshock level. Concerning these findings, the following statement is quoted from the published work of these investigators(11):

> The [nitrous oxide] method is inapplicable during convulsions, not only because of the presence of needles in a . . . . femoral artery, but also because a steady state of at least ten minutes is required for each measurement. The effects of convulsions induced electrically therefore, could only be studied at a time (usually about 10 minutes) after the first convulsion, when a steady state was again present.

From the data obtained in the present study, it is obvious that, by the end of a 10-minute interval from the onset of the convulsion, the significant changes in blood flow and systemic pressure associated with electroshock have subsided.

Our findings are not in accord with those reported by Kreienberg and Ehrhardt(16) who studied blood flow in dogs with the use of a thermostromuhr. They reported a complete blockage of cerebral circulation during the passage of the current; after the application of the current and during the convulsions, a fall in blood pressure and an increase in blood flow was reported. It would appear that the circulatory arrest they observed was due to excessive duration of shock stimulus, since we found that, unless the shock duration was appreciably longer than 0.2 second, the volume of blood flow through the carotid artery was decreased during the current flow, but complete stoppage of circulation was not observed. The sequence of a fall in blood pressure with an increase in carotid flow, which they report, cannot be explained since this pattern was not observed once in our investigation.

Reitman and Richards(5), from a study of vasodilator drugs in 16 patients, conclude that cerebral vasoconstriction is one of the basic mechanisms involved in electrically induced convulsions. Although there is considerable evidence opposing such a view, as compiled by Schmidt(18), a decrease in cerebral flow resulting in cerebral ischemia has been postulated by other investigators (6-10).

The results of our experiments offer indirect evidence against the concept that cerebral ischemia plays a significant role in ECT. The blood flow through the carotid artery was more than doubled during the convulsions following shock and required several minutes to return to preshock levels. Both the systolic and diastolic blood pressures were markedly elevated during the convulsions and also required several minutes to subside to control levels.

Preliminary experiments in the elevation of intracranial pressure indicate that most of the blood flowing through the common carotid artery of the dog is delivered to intracranial vessels since, when the intracranial pressure is raised to the extent that it is impossible for blood to enter the intracranial cavity, there is a 70% decrease in blood flow in the common carotid artery(19).

Vasoconstriction of extensive functional significance in the cerebral vessels of a dog subjected to head trauma seems unlikely. It is equally doubtful that vasodilatation occurs to any marked degree.

If, in a vascular bed as large as the cerebral bed, vasoconstriction occurred to any great extent as a result of ECS, there should be a decrease in blood flow as measured in

the common carotid artery coexistent with an increase in blood pressure. Conversely, if an extensive degree of vasodilatation were to occur, the blood pressure should decrease concomitantly with an increase in carotid blood flow. Neither of these responses was observed in this study: blood flow in the carotid artery and arterial pressure increased concomitantly and decreased concomitantly. Thus, it is concluded that, in the dog, functional changes in cerebral blood flow probably occur as a passive response to marked changes in arterial pressure.

The literature concerning the effects of ECS on blood pressure has been reviewed recently(20). In studies on human subjects, it is difficult to record blood pressure changes during convulsions. In the present study on dogs, both systolic and diastolic pressure increased to the highest levels during the convulsions and remained above control levels after the conclusion of the convulsions and the respiratory arrest. Thus, the changes in head pressure, an important factor in determining the volume of cerebral blood flow, are in the direction favoring increased rather than decreased intracranial blood flow. Silfverskiold and Åmark(9) report a pattern of arterial pressure events following ECS that is similar in time and direction to the pattern described in the present study.

The response of the cardiac rate to ECS in this series of dogs is an initial, very brief bradycardia followed by a prolonged tachycardia; this is the reverse pattern reported by Abély *et al.* and Lainé (reported by Wilcox(21)). The initial bradycardia is believed to be due to transient stimulation of the cardio-inhibitory centers or nerves, inasmuch as bradycardia was not observed in a vagotomized animal. This initial, momentary slowing of the heart caused a diminished cardiac output and a fall in blood pressure for one second postshock. Due to the relatively brief time interval involved, the one-second diminution in heart rate, blood flow, and arterial pressure is not considered to be of therapeutic significance. Cardiac arrhythmia was observed during the long phase of tachycardia and is thought to be due to competitive influences of vagal and orthosympathetic stimulation, since arrhythmia was not observed following vagotomy. The marked and prolonged secondary increases in cardiac rate and blood pressure may be sustained by intermittent vagal inhibition and reciprocal excitation of orthosympathetic activity via direct electrical effects and/or direct and reflex effects from alterations in the chemical environment. Stimulation due to changes in pH does not appear to play a significant role(15). Anoxia is probably not a major mechanism operating since, in one investigation reported(9), 100% oxygen was inhaled by subjects before ECT and the same pressure patterns were observed as were found in the present study. Holmberg and Lahne(22) report that 100% oxygen inhalation greatly reduces the oxygen desaturation of blood during ECT.

It has been suggested(21) that the convulsions "cause" the autonomic excitation following electroshock. This view is not supported by the data in the present investigation. In a preliminary study, the blood flow, arterial pressure, and heart rate recordings showed identical patterns of response for subconvulsive shocks as for convulsive shocks. This fact suggests that, whereas the convulsion may augment the cardiovascular changes subsequent to electroshock, the changes are independent of the convulsion, *per se*, and result from some action initiated by the shock stimulus itself. Since curarized patients do not undergo convulsive seizures in ECT and are reported to exhibit the same clinical improvement as noncurarized patients treated by ECT, the therapeutic benefit of convulsions has been questioned. Marked cardiovascular changes are a common denominator in both convulsive and subconvulsive electroshock and these changes may occur in curarized patients undergoing electroshock, also. Further work may determine the significance of these cardiovascular responses to electroshock.

Summary and Conclusions

The immediate effects of ECS on the carotid blood flow, arterial pressure, and cardiac rate were recorded in experiments on a series of 16 unanesthetized dogs. The shock stimulus in terms of milliamperage, voltage, and duration of the electrical current were also recorded.

Blood flow was measured continuously by the use of an electromagnetic blood flow

meter. Blood pressure was measured directly and continuously in the femoral artery through the use of a Statham Gage-Brush recorder system.

All operative procedure was carried out under general ether and/or local procaine anesthesia.

The initial responses to ECS were convulsions, respiratory arrest, bradycardia, and reduced carotid blood flow and arterial pressure; the latter 3 responses had a duration of one second. The bradycardia could be prevented by vagotomy. The initial decrement in these entities was followed by a prolonged secondary increase above control levels. Blood flow and arterial pressure reached their highest elevations concomitantly and then, while the convulsions continued and respiration was resumed, they began a gradual decline, until at 10 and 5 minutes, respectively, a majority of the 16 animals had returned to control levels of blood flow and arterial pressure. Cardiac rate did not reach a peak until the respiratory arrest and convulsions had ceased; the peak value was maintained for several seconds followed by a gradual return to control level that was attained by about 5 minutes post-shock.

This study offers indirect evidence against the concept that the therapeutic effects of electroconvulsive therapy are due to cerebral ischemia resulting from widespread cerebral vasoconstriction.

Changes in blood flow in the carotid artery of dogs appear to be a passive response to marked changes in systemic pressure.

Whereas convulsions may augment the cardiovascular changes subsequent to electroshock, these changes are independent of the convulsions, *per se*, since the same patterns of response occur in subconvulsive electroshock. The significance of these cardiovascular changes in ECT has yet to be determined.

BIBLIOGRAPHY

1. Revised Electroshock Therapy Report. Report No. 15, August 1950, Committee on Therapy of the Group for the Advancement of Psychiatry.

2. Gordon, H. L. Fifty shock therapy theories. Mil. Surg., **103**: 397, 1948.

3. La Valette, as reported by Paul H. Wilcox. Chapter on shock therapy in Progress in Neurology and Psychiatry. New York, Grune and Stratton, 1947.

4. Altschule, W., et al. Effect of electrically induced convulsions on peripheral venous pressure in man. Arch. Neurol. and Psychiat., **58**: 193, 1947.

5. Reitman, F., and Richards, B. W. Observation on the mechanism of electrically induced convulsions. J. Nerv. and Ment. Dis., **102**: 421, 1945.

6. Alexander, L., and Loewenbach, H. Experimental studies on electro-shock treatment. J. Neuropathol. and Exper. Neurol., **3**: 139, 1944.

7. Alpers, B. J. The brain changes associated with electrical shock treatment: A critical review. Journal Lancet, **66**: 363, 1946.

8. Gordh, T., and Silfverskiold, B. F. Disturbance of circulation in convulsions of epileptic type. I. Intra-thoracic and intra-abdominal pressure during electro-shock. Acta Med. Scand., **113**: 183, 1943.

9. Silfverskiold, B. F., and Amark, C. Disturbance of circulation in convulsions of the epileptic type. II. Arterial and venous pressure during electroshock. Acta Med. Scand., **113**: 191, 1943.

10. Kety, S. S., et al. Cerebral blood flow and metabolism in schizophrenia. The effects of barbiturate semi-narcosis, insulin coma and electroshock. Am. J. Psychiat., **104**: 765, 1948.

11. Schmidt, Carl F. The Cerebral Circulation in Health and Disease, p. 64. Springfield: C. C. Thomas, 1950.

12. Gibbs, F. A. Cerebral blood flow preceding and accompanying experimental convulsions. Arch. Neurol. and Psychiat., **30**: 1003, 1933.

13. Gibbs, F. A., et al. Cerebral blood flow preceding and accompanying epileptic seizures in man. Arch. Neurol. and Psychiat., **32**: 257, 1934.

14. Penfield, W., et al. Cerebral blood flow during induced epileptiform seizures in animals and man. J. Neurophysiol., **2**: 257, 1939.

15. Jasper, H., and Erickson, T. Cerebral blood flow and pH in excessive cortical discharge induced by metrazol and electrical stimulation. J. Neurophysiol., **4**: 333, 1941.

16. Kreienberg, W. V., and Ehrhardt, H. Cerebral blood flow in electroshock. (Die Gehirndurchbluntung im Elektroschock.) Nervenarzt, **18**: 154, 1947.

17. Richardson, A. W., et al. A newly developed electromagnetic flow meter. J. Lab. and Clin. Med., **34**: 1706, 1949.

18. Schmidt, C. F. The Cerebral Circulation in Health and Disease. Springfield, Charles C. Thomas, 1950.

19. Brown, G. W. et al. Cardiovascular and Respiratory Changes Associated with Experimental Concussion in Dogs. Air Force Technical Report No. 6737, USAF Research and Development Contract.

20. Igersheimer, W. W., and Stevenson, J. A. F. Effect of electroshock on the blood pressure in psychotic patients. Arch. Neurol. and Psychiat., **65**: 740, June 1951.

21. Wilcox, Paul H. Chapter on shock therapy in Progress in Neurology and Psychiatry. New York, Grune and Stratton, 1949.

22. Holmberg, G., and Lahne, B. Hypoxämien vid elektroshock-behandling. Nordisk Medicin (Stockholm), **43**: 1052, June 1950.

SURVEY OF THE FIRST TWO YEARS OF ELECTRIC SHOCK TREATMENT IN A LARGE PRIVATE HOSPITAL

FEIGA GROSS, M. D., Brattleboro, Vt.

The purpose of this paper is to report a unique experience in the use of electric shock in a hospital of 700 patients, and to indicate the results of the first 2 years' work. It should be said at once that bringing more modern therapies to an entirely custodial institution has to a large degree changed the character of the institution; during the second year, in spite of a 38% increase in admissions, there was less than 1% increase in the average daily census.

A group of 249 patients received electroshock therapy at the Brattleboro Retreat during the years 1949-1951. This group included 90 manic-depressive patients, 45 patients with involutional psychosis, 92 schizophrenics, 4 psychosis with mental deficiency, 2 paranoid conditions, and 1 psychosis with convulsive disorder. The ages of the patients varied from 20-75 years, the duration of the illness from 3 days to 38 years, the number of treatments from 4-140.

The best results were obtained from electric convulsive therapy in affective disorders, mainly in early cases. The percentage of recovery is as high as 81% in manic-depressive, depressed, and 85% in involutional melancholia in patients who have been ill less than one year. The percentage of recovery in nonaffective disorders is much lower, even in early cases.

Technique

In our survey, both acute and chronic conditions are present. We treated the patients at a rate of 3 treatments or more a week, depending on the type of illness and the response of the patient to the first few treatments. After a series of 9 treatments is completed, the patient is given a rest and observation period for 3 weeks. During that period the patient will either achieve an uneventful recovery or suffer a relapse, a short psychotic episode, or an acute panicky reaction not related to the initial psychosis. A few additional treatments usually will clear up the psychosis.

Once in a while during the treatment a manic will shift to a depression, at which time a few additional treatments are necessary.

An increased number of treatments is needed for the acutely disturbed patient. To those, electroshock treatments are given 3 or 4 times daily for a few days. Regardless of the increased confusion, the patient soon clears up and becomes accessible to psychotherapy.

Use with Chronic Patients

Chronic patients who have been institutionalized for many years and have exhausted all preshock treatments, including hydrotherapy, sedatives, and restraints, get considerable benefit from electric convulsive therapy. Since improvement is slow, and shows a tendency to relapse, more treatments are needed. The patients are treated symptomatically at the reappearance of the symptoms. A so-called maintenance treatment is instituted once or twice weekly, according to the need. The patients who have been destructive, noisy, untidy, refusing food —after being treated relax, become more cooperative, and feed themselves. They start taking part in occupational and recreational activities, also take better care of their appearance. As a result they are moved to better wards and even allowed to go home for short visits. The management of the ward is much easier; whereas before a considerable number of nurses was necessary to care for the disturbed patients, we now can get along with a much smaller force, a fact that is appreciated because of the present shortage of hospital help.

We have treated elderly sclerotics, agitated seniles, patients with old coronary disease, patients who have tuberculosis in a latent state, and one case of pregnancy. So far we have had no serious injury during the treatments.

ANALYSIS OF ELECTRIC SHOCK THERAPY DURING THE FIRST 2 YEARS

	Duration of illness and result											
	Less than 1 year				1-2 years				2 years and over			
	Number treated	Result			Number treated	Result			Number treated	Result		
		R.	I.	U.		R.	I.	U.		R.	I.	U.
Manic depressive psychosis												
Depressed	48	39	8	1	6	4	2	0	17	3	13	1
Manic	11	8	2	1	0	0	0	0	4	1	3	0
Mixed	3	2	1	0	0	0	0	0	0	0	0	0
Other types	1	0	1	0	0	0	0	0	0	0	0	0
Involutional psychosis												
Melancholia	26	22	4	0	2	2	0	0	10	4	6	0
Paranoid	2	2	0	0	0	0	0	0	3	0	0	3
Other types	0	0	0	0	0	0	0	0	1	1	0	0
Mixed	0	0	0	0	0	0	0	0	1	1	0	0
Schizophrenia												
Catatonic	19	3	13	3	4	0	4	0	19	2	12	5
Paranoid	14	4	7	3	2	0	2	0	14	1	9	4
Hebephrenic	5	1	4	0	0	0	0	0	2	0	2	0
Simple	2	0	2	0	0	0	0	0	1	0	0	1
Other types	4	3	1	0	1	0	1	0	5	0	5	0
Psychosis with convulsive disorder	0	0	0	0	1	1	0	0	0	0	0	0
Psychoneurosis												
Anxiety	1	1	0	0	0	0	0	0	0	0	0	0
Reactive depression	3	3	0	0	0	0	0	0	3	0	3	0
Hysteria	0	0	0	0	0	0	0	0	1	0	0	1
Hypochondriasis	2	0	2	0	0	0	0	0	0	0	0	0
Psychasthenia	1	0	1	0	0	0	0	0	1	1	0	0
Mixed	1	0	1	0	0	0	0	0	2	0	2	0
Psychosis with mental deficiency	2	0	2	0	0	0	0	0	2	1	1	0
Paranoid condition	1	1	0	0	0	0	0	0	1	0	1	0
Totals	146	89	49	8	16	7	9	0	87	14	58	15

* In classifying our groups we used the Table of Analysis of Electroshock Therapy presented by Creedmoor State Hospital at their Twentieth Annual Report to the Department of Mental Health. This table is clear and easy to follow.

Results Obtained

Of our group of 249 patients 110 (46.8%) have recovered, 116 (48.2%) improved, and 23 (6%) unimproved. We discharged 161 patients, which number included 100% of the group of recovered, and part of the improved group (51=43%). Eighty-eight patients (65 improved and 23 unimproved) are still in the hospital. Some of them are getting symptomatic treatments and the others have made a satisfactory hospital adjustment. Of the 23 unimproved, 3 are being treated with insulin shock therapy. The other 20 failed to respond to electroshock therapy because of advanced deterioration.

Type of Machine in Use

The only machine used was the Reiter electro-stimulator. It is our opinion that this is a very satisfactory and safe machine to use. There appears to us to be absolutely no need of curare or other medication to prevent injury. In practical terms, the reason for this is that the machine itself maintains throughout the treatment a rigidity of the complete muscular system that prevents extreme jerking of muscle groups, which, with certain other equipment, produces fractures. This principle of stiffening the muscles is the opposite of that involved in the use of curare, which weakens muscular activity. In our opinion it is safer and more effective. In any case, with careful observation, we have had no fractures traceable to electroshock. The only accidents of this nature we have had are recurrence of an old displaced meniscus, one Colles' fracture of the wrist of unknown cause, and the tearing of the fibrous union of an old femoral fracture. The only other accident of any kind was production of burns at the site of electrodes. This seemed to be related closely to individual susceptibility but also quite definitely to the amount of current used and has been controlled by keeping the amount of current to the minimum required to produce a convulsion.

SUMMARY

This paper reports the summary of 2 years' use of electroshock treatment with the Reiter electro-stimulator at the Brattleboro Retreat, where electric shock had not previously been used. Number of patients treated was 249, of whom 161 or 65% were discharged. Of the total, only 23 or 6% were unimproved, but 88 of those treated are still in the hospital. As reported elsewhere there was a marked decrease in the percentage of recoveries when duration of illness was longer than one year.

PEPTIC ULCER

Incidence and Diagnosis in Psychotic Patients[1]

BETTIE M. WEST, M. D., and ARTHUR O. HECKER, M. D.,
Coatesville, Pa.

Despite a general and almost traditional impression that the incidence of peptic ulcer is remarkably low among hospitalized psychotic patients, we could find no evidence in the literature in support of this contention. On a much broader scale Kahn and Freyhan (1) contend that there is no factual substantiation for the even more prevalent premise that peptic ulcer is a psychosomatic illness. Our own interest in the problem of peptic ulcer among psychotic patients stems in part from the contention of Kahn and Freyhan, from our own clinical experiences, and from the paucity of information related to peptic ulcer and the psychotic states. On this latter subject, the only adequate reference found was a paper by Pollock and Kreplick (2). In their analysis of autopsy material from 2,000 psychotic patients, they report an incidence of peptic ulcer of 2.1%. In our own limited material, we can report a 3% incidence of gross peptic ulcer in 130 cadavers of psychotic patients studied over a 3-year period.

Studies of cadavers the world over for incidence of peptic ulcer date from as early as 1859 and are summarized in a paper by Gordon and Manning (3), who in turn report an incidence of 2.75% in 22,956 cadavers examined at Philadelphia General Hospital from 1920 to 1937. Sturtevant and Shapiro (4) report an incidence in autopsy material from Bellevue Hospital, New York, of 2.13%, whereas Portis and Jaffé (5) report 339 cases of peptic ulcer in 9,171 consecutive autopsies at Cook County Hospital, Chicago, an incidence of 3.59%. Thus, it would seem from the material available that the incidence of peptic ulcer found at autopsy is within a comparable statistical range whether from psychotic or nonpsychotic hospital patients.

In addition to data on autopsy material, Pollak and Kreplich noted that only a small number of psychotic patients express clinical symptoms of peptic ulcer during life. This has also been our experience. Of 33 cases of peptic ulcer diagnosed at our hospital within a 4-year period, only 8 patients complained of epigastric pain, and 14 patients offered no subjective symptoms. In this group of 33 patients, the diagnosis was established by roentgenological examination in 12; roentgenological examination and operation in 11; by operation in 6; and by autopsy in 4. Of more interest is the fact that, of 18 patients operated on, 16 needed surgery for major complications: 8 for hemorrhage, 5 for perforation, and 3 for obstruction. In many of these cases the complications of peptic ulcer such as hemorrhage, perforation, or obstruction constituted the first evidence presented of the existence of the lesion.

In general, the usual problems attending the clinical diagnosis of peptic ulcer are compounded in the psychotic patient by two factors: (1) the patient who offers no subjective complaints, (2) the patient who confounds the diagnosis with irrelevant or delusional productions.

Illustrative Case Material (Group 1)

H. R., age 51 white male. Diagnosis: schizophrenic reaction, hebephrenic type. The patient was described as being dull, seclusive, introverted, and emotionally deteriorated. He had offered no complaints referable to the gastrointestinal tract from the time of his admission 2/3/33 and appeared to be in good health. He had had no weight loss. On the evening of 8/1/51 he attended a party given for his ward. When returning to his ward, he was observed vomiting thin, watery, fluid. He began moaning unintelligibly. Although he seemed to be in acute pain, he denied it. His skin was cold, clammy, and he was perspiring profusely. His abdomen showed board-like rigidity and absent peristalsis. B.P. 110/70. Temperature 99°. Pulse 22 and respirations 24. Patient was prepared for surgery. Operation revealed a perforated duodenal

[1] Sponsored by the VA and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are a result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

ulcer. Closure of the perforated duodenal ulcer was done. Postoperative course has been good.

F. K., age 63, white male. Diagnosis: schizophrenic reaction, paranoid type. This patient has arteriosclerotic heart disease with old anteroseptal and lateral myocardial infarction and anginal syndrome. He had had severe anginal attacks for at least 10 years. These were relieved by nitroglycerin under the tongue. He had also had several attacks of thrombophlebitis of the saphenous vein, left thigh. Complaints had always been referable to the precordium, left shoulder, and left arm. Repeated physical examination failed to reveal any abnormalities, tenderness, or rigidity of the abdomen. He persistently denied epigastric pain, never had any nausea or vomiting. Because of continued, gradual loss of weight (168 lb. 4/1/50 to 128 lb. 4/1/51) a GI series was done 4/27/51. A deformed duodenal bulb due to chronic, active duodenal ulcer was found. Patient is now on medical ulcer regime and is improving.

G. G., age 53, white male. Diagnosis: general paralysis, cerebral type. This patient offered no complaints and appeared to be in good physical condition, from the time of his admission 11/25/41 to 9/1/50. The one exception was an episode of vomiting in February 1945. It was reported that the food vomited was the same as that served in the mess hall. There was no indication of acute pathology and no persistence or recurrence of vomiting. On 9/1/50 the patient suddenly became ill in the dining room. He became faint, weak, dizzy and perspired freely. He recovered rapidly, offered no complaints, and said that he felt well. A CBC was ordered and an anemia of 2.85 RBC and 8 gm. hemoglobin was reported. He still offered no complaints and denied pain. B.P. 102/54. The abdomen was obese, with no apparent rigidity or tenderness. Peristalsis was active. Rectal examination revealed tarry feces. GI series revealed a nonobstructive, active duodenal ulcer. The patient was treated medically and, when his condition warranted it, on 10/11/50 a subtotal gastrectomy was done. Postoperatively, the patient had an uneventful recovery, and he is now in good physical health. Recent comparative GI series reports: partial gastrectomy with normally functioning stoma.

Illustrative Case Material (Group 2)

D. Q., Jr., age 53, white male. Admitted 11/21/32. Diagnosis: schizophrenic reaction, simple type. This patient, who during his hospitalization, had offered no complaints referable to his gastrointestinal tract, was apparently well until the morning of 3/14/51. At that time it was noticed that he was staggering, dyspneic, cyanotic, and appeared to be acutely ill. His only complaint was of a chest cold, and he persistently denied any symptoms, repeating, "I just have a chest cold; that's all." Temperature 106° rectally. Pulse 120 irregular, thready and weak. Respirations 40. B.P. 48/0. Skin was cold and clammy, and there was profuse diaphoresis. The abdomen was markedly distended, rigid, and tympanitic. Peristalsis was hypoactive. Though the patient denied abdominal pain or tenderness, it was obvious on palpation. His pupils became dilated and he grimaced markedly when the abdomen was touched. In spite of intensive medical treatment, the patient continued in profound shock and died the same day. Autopsy revealed generalized peritonitis due to perforation of a chronic duodenal ulcer.

W. G., age 52, white male. Diagnosis: schizophrenic reaction, paranoid type. On admission 11/18/34, this patient complained of indigestion, constipation, gas on stomach after eating and pain in mid-stomach. He claimed that his food was either doped or poisoned. Throughout his entire hospitalization he had many continued somatic complaints; *e.g.*, "My heart beats slowly and sometimes stops." "I need oxygen for my left lung." "My spleen is paralyzed and my red corpuscles don't go through my body." He had had progressive weight loss through the years. His weight on admission was 124. On 10/24/47 it was 99. Patient was sent to the medical ward for study because of the weight loss. A complete medical workup including gastric analysis and gastrointestinal series, both of which showed no abnormalities, was done. Somatic complaints, mostly referable to the stomach, continued, but in view of the negative studies and past history, they were not thought to be indicative of organic disease. On 5/28/48 the patient vomited "coffee ground" material and complained of severe abdominal pain. Temperature 101° rectally. Pulse 120, respirations 24, blood pressure 90/62. The abdomen was markedly distended, rigid, and peristalsis was absent. Patient was prepared for surgery. During the operation, he expired. Generalized peritonitis due to a perforated duodenal ulcer was discovered. X-ray films of 1947 were reviewed and, in retrospect, it was the opinion that an ulcer was present at this time but had not been discerned.

From these illustrative cases it can be seen that reliance upon the patient's presenting symptomatology in the ordinarily expected manner cannot be considered an essential part of the diagnosis of peptic ulcer in the psychotic patient. This places the burden of diagnosis upon the ability of professional personnel to recognize suggestive signs that require specific medical, laboratory, and roentgenologic study.

In our group of patients the most common signs found were as follows: epigastric tenderness (16), weight loss (10), melena (9), hematemesis (9), vomiting (7), and anemia (4). Nine patients were not suspected of having peptic ulcer until the signs of shock or peritonitis developed as a result of rupture or obstruction.

The incidence of peptic ulcer spreads across psychiatric diagnostic categories and

age groups. Eighteen cases (54.6%) occurred among schizophrenics; 13 among organic reaction types (39.4%), and 2 (6.0%) among psychoneurotics. Age incidence at time of diagnosis ranged from 26 years to 79 years, with the highest incidence between the ages of 47 and 66; 57% of cases fell within this age group.

It is difficult to arrive at any accurate figures as to the actual incidence of peptic ulcer in the population. Bockus(6) states that many investigators place the figure at approximately 10% of the population, and quotes Jennison's figure of 7% incidence among 2,700 employees of a large insurance company examined by fluoroscopy. However, these figures are not comparable to hospital figures obtained when peptic ulcer is diagnosed on the basis of initial symptomatological leads followed by special examinations, rather than on comprehensive surveys. During the period for which we report the 33 cases mentioned previously, a total of 3,320 patients (male) were hospitalized in this hospital. This would give an incidence of 1% of diagnosed peptic ulcer among our patients. Portis and Jaffé(5) found that, of 67,871 admissions to the Cook County Hospital in 1934, 0.88% were diagnosed clinically and roentgenographically as having peptic ulcer. These figures are at variance with the higher estimates quoted by Bockus, but so large a survey cannot be discounted. It is of further interest to note that, during an 8-week period following the presentation of the above data at a clinical-pathological conference, *7 additional cases of peptic ulcer were brought to light among our own patient population.* This approximate 20% increase in cases diagnosed by us after clinical stimulation to awareness of the problem would seem to indicate that the reputed low incidence of peptic ulcer among psychotic patients is occasioned by the difficulties attending diagnosis rather than by actual facts.

SUMMARY

A survey of the literature as well as of our case material indicates that peptic ulcer is common among psychotic patients, the incidence in hospital populations of mental and general hospitals being within comparable statistical range or perhaps of higher range in mental hospitals. These studies indicate further that the reputed low incidence is based on increased difficulties of diagnosis in the psychotic patient rather than on actual evidence.

BIBLIOGRAPHY

1. Kahn, E., and Freyhan, F. A. Peptic ulcer—facts and assumptions. Am. J. Psychiat., **107**: 866, 1951.

2. Pollak, O. J., and Kreplick, F. Peptic ulcers in the insane; Clinical and postmortem study. J. Nerv. & Ment. Dis., **101**: 1, 1945.

3. Gordon, J. S., Jr., and Manning, J. J. An autopsy survey of gastro-duodenal ulcers in the Philadelphia General Hospital 1920-1937. Am. J. M. Sci., **202**: 423, 1941.

4. Sturtevant, M., and Shapiro, L. L. Gastric and duodenal ulcer: Frequency, number, size, shape, location, color, sex and age in 7,700 necropsy records at Bellevue Hospital, New York. Arch. Int. Med., **38**: 41, 1926.

5. Portis, S. A., and Jaffé, R. H. A study of peptic ulcer based on necropsy records. J.A.M.A., **110**: 6, 1938.

6. Bockus, H. L. Gastro-enterology. Philadelphia: W. B. Saunders Co., 1944.

THE USE OF METHEDRINE IN THE DIAGNOSIS AND TREATMENT OF THE PSYCHONEUROSES

T. M. LING, M. D., M. R. C. P.,[1] AND L. S. DAVIES, M. R. C. S., L. R. C. P.[2]

Horsham, Sussex, England

This study was undertaken to determine the psychological and psychiatric actions of d-N-Methylamphetamine Hydrochloride (methedrine) with a view to its use for diagnostic and therapeutic purposes in cases of psychoneurosis.

A comparable study was first made in 1948 by Julius Levine *et al.*(1). Their work covered a critical survey of 75 cases, of which 23 were suffering from a psychoneurosis and 10 were examples of psychopathic personalities. Since that date Monro and Conitzer(2) made a comparison of desoxyephedrine and electroplexy in the treatment of depressions; Cuthbertson and Knox(3) the effects of the same preparation on the fatigued subject; L. M. Eaton(4) on the treatment of narcolepsy with methedrine. Professor Delay(5) has reviewed the pharmacological explorations of the personality with narco-analysis and methedrine shock; Rudolf(6) the treatment of depressions with the same drug. Myerson(7) has reported on the treatment of hysterical amnesia by purely pharmacological means; Hope *et al.*(8) have published a critical survey of the effect of this drug in schizophrenia; Honorio Delgado and Andres Carrillo-Broatch(9) on its effects in depression; Simon and Taube(11) and Belart(12) with special reference to treatment.

In 1950 Shorvon(13) reported an interesting series of cases to the Royal Society of Medicine in London with special reference to psychological obesity and another series of the results obtained in neurodermatitis some months later. In the later paper, Shorvon(14) produced clinical evidence of marked improvement in otherwise intractable cases of neurodermatitis. Some of the writers, *e.g.*, Jackson and Monro, concluded that the use of this drug in cases with marked anxiety tended to worsen the condition. With these variable results in mind, this series was undertaken.

Clinical material included both sexes and age groups of 20-50. The duration of the illnesses varied from 6 months to 6 years and a total of 140 cases was treated. The intravenous route was adopted to enable the immediate effects of the drug to be studied. Each patient was kept under close observation for one hour and under the direct supervision of the nursing staff for a further period of 24 hours. This time was spent by the patient in a room on his own with paper and pencil to enable him to record any relevant material. Each patient underwent a careful clinical assessment with special reference to the cardiovascular system.

The physiological effects were the same as described by Levine *et al.*

Case Reports

A 48-year old female who had had a complete hysterectomy 4 years previously had developed pruritus vulvæ. Methedrine uncovered her profound fear of carcinoma, a fear that had prevented her working for 6 months. Although previously her sexual life had been well adjusted, under the drug she admitted her fear that sexual intercourse might light up the "roots" of the cancer that might have been left behind. On the other hand, she felt she should be a wife in the physiological sense. The tension arising from this emotional conflict was completely dissipated by repeated injections. Her pruritus disappeared and she remained symptom-free and working for 3 months after discharge.

A young man gave a history of lifelong dermatitis, and had been hospitalised for periods of months at a time from the age of 5. Although he had suffered very considerably before the age of puberty, the condition worsened when he tried to adjust to work and he was never settled in one job owing to his condition. He had been accepted for military service, but had been invalided out within 8 weeks. It was felt, originally, that the deterioration of the skin condition might well be attributed to the additional psychological disturbance associated with adolescence. However, under methedrine he abreacted violently to an incestuous incident at age 15, and to other sexual incidents. At the time of his admission to hospital his face and extremities were the seat of intractable atopic eczema. He had received the usual range of treatment from lotions to X-rays. Following treatment and appropriate resettlement, this patient has made a very satisfactory readjustment.

One other young woman, who had been admitted

[1] Medical director, Roffey Park Rehabilitation Centre, Horsham, Sussex, England.

[2] Medical officer of the same unit.

to this unit 2 years ago suffering from marked anxiety with somatic and phobic symptoms, had been treated unsuccessfully. Upon re-admission, an emotionally charged situation was uncovered revealing that a man who had seduced her prior to her marriage was now blackmailing her. After 3 treatments at weekly intervals, this painful situation had lost its emotional charge and the young woman was enabled to face the situation objectively with excellent clinical results.

Another man suffering from anxiety with respiratory symptoms had previously been under treatment in a general hospital for a supposedly spasmodic pulmonary asthma, and had remained under treatment for 12 months, with negative results. In this particular instance, methedrine uncovered serious marital and occupational difficulties, which the patient was able, subsequently, to handle quite satisfactorily.

A professional woman, aged 44, had suffered severely from a syndrome—depression, anxiety, insomnia, fatigue, mental and physical, dyspepsia—of gradual onset, culminating in complete disability 8 months before admission. She had been brought up in a strict religious home. At interview she was ready enough to discuss the consummation of an engagement resulting in an illegitimate child 10 years ago. It was felt at another hospital that she was suffering from involutional depression, but 7 electroplexies failed to produce any improvement. She was explored under methedrine, and abreacted violently to an emotionally charged situation involving homosexuality with a woman of high social status during the previous 6 years. Repeated abreaction dispelled the tension-inducing situation, with excellent results. She has continued at work for 3 months symptom-free.

A lorry-driver, aged 23, had been involved in a road accident 3 months before admission. There was a posttraumatic amnesia of 48 hours. Under methedrine he abreacted violently, the patient reliving the experience he underwent when his lorry blew up in flames. Not only was this incident recalled, but the drug uncovered a comparable bombing experience during a severe London air-raid, the patient reliving the terrors of being buried in a burning house. He made a satisfactory recovery.

Another patient, an anxiety state with somatic features, uncovered extremely painful childhood memories of an unhappy life in a convent in Ireland.

These are but a few of the outstanding cases in which material became accessible, where the patients relived their painful traumatic experiences with dramatic relief of tension, and a feeling of relaxation. In the cases that abreacted, the drug was of therapeutic value. In others, the use of the drug uncovered material available to the patient's consciousness for integration and assimilation.

Conclusion

From this study of 140 cases, it is concluded that d-N-Methylamphetamine Hydrochloride or methedrine, when used in psychoneurotic illnesses, particularly in chronic anxiety states, neurodermatitis, and the acute posttraumatic anxieties, produces an emotionally free-flow material that may include painful memories of traumatic experiences, and that will provide the patient with permanent relief.

In the majority of cases, the responses evoked are helpful, both diagnostically and therapeutically.

BIBLIOGRAPHY

1. Levine, Julius, et al. Psychological and physiological effects of intravenous pervitin. Am. J. Psychiat., **105**: 429, Dec. 1948.

2. Monro, A. B., and Conitzer, H. A comparison of methedrine and E.C.T. in the treatment of depression. J. Ment. Sci., **96**: 405, Oct. 1950.

3. Cuthbertson, D. P., and Knox, J. A. C. The effect of analeptics on the fatigued subject. J. Physiol., **106**: 42, 1947.

4. Eaton, L. M. Treatment of narcolepsy with Desoxyephedrine Hydrochloride. Proc. Staff Meet. Mayo Clin., **18**: 262, 1943.

5. Delay, J. Pharmacological exploration of the personality: Narco-analysis and methedrine shock. Proc. Roy. Soc. Med., **42**: 491, July 1949.

6. Rudolf, G. de M. Treatment of depression with desoxyephedrine. J. Ment. Sci., **95**: 920, Oct. 1949.

7. Myerson, Abraham. The treatment of hysteric amnesia by purely pharmacologic means. New Eng. J. Med., **236**: 821, May 29, 1947.

8. Hope, Justin, et al. Intravenous pervitin and the psychopathology of schizophrenia. Dis. Nerv. Sys., **12**: 3, 1951.

9. Delgade, Honario, and Carillo-Broatch, Andres. Treatment of depression and agitation with desoxyephedrine hydrochloride. Rev. Neuro-Psiquiat., **13**: 539, Dec. 1950.

10. Jackson, D. D. The use of d-Desoxyephedrine in neuro-psychiatry. Texas Rep. Biol. & Med., **4**: 10, 1946.

11. Simon, J. L., and Taube, H. A preliminary study on the use of methedrine in psychiatric diagnosis. J. Nerv. Ment. Dis., **104**: 593, Dec. 1946.

12. Belart, W. Pathogenic and therapeutic data obtained in tests with pervitin in schizophrenia. Scheiz. med. Wschr., **72**: 41, 1942.

13. Shorvon, H. J. The result of intravenous methedrine in traumatic obesity. Proc. Roy. Soc. Med., **43**: 801, Nov. 1950.

14. Shorvon, H. J., et al. Survey of the use of intravenous methedrine in neuro-dermatitis. B.M.J., **2**: 1300, 1950.

AN EARLY SUGGESTION FOR THE CARE OF THE INSANE IN RHODE ISLAND

A. WARREN STEARNS, M. D., BILLERICA, MASS.

The beginning of the institutional care of handicapped persons is somewhat obscure. Throughout the Middle Ages there were, apparently, dungeons or "keeps," where dangerous or refractory persons were kept pending execution or judgment, and under religious auspices there were hospices or benefices, or whatnot, where sick, disabled, or otherwise "impotent" persons might be kept.

The Hospital of St. Mary of Bethlehem ("Bedlam") dates from 1247, when Simon FitzMary, a man of wealth and influence, ceded land to the Bishop of Bethlehem for the establishment of a priory. Here shelter to "the poor, the stranger, and the pilgrim and succour to all Christians in any other affliction" were afforded, and certainly as early as 1377 (perhaps prior to that date) the insane were housed. The Hôtel Dieu of Paris was founded between 641 and 691 by St. Landry, Bishop of Paris, as a charitable institution furnishing every form of aid to the poor and needy. Already during the Middle Ages, it had a special department for the mentally ill. If treatment there failed, the male patients were sent to the Bicêtre (1250); the female, to Sàlpetrière (1656). St. Bartholomew's Hospital was started in 1123 by a court jester turned monk. Sellin writes an interesting account of the first house of correction in Holland (1589). When Henry VIII seized the church property, in the early 16th century, he turned over a castle known as Bridewell for the care of dissolute and needy persons who, before that period, had depended upon ecclesiastical charity for support.

In America, houses of correction were established, or at least authorized, very early. The following Massachusetts law was passed on May 28, 1629:

> And for the better gouning and ordering of o' people, espetialle such as shalbe negligent and remiss in pformance of their dutyes, or otherwise exorbitant o' desire is, that a house of correccon bee erected and set vpp, both for the punishm' of such offendo's, and to deterr others by their example from such irregular courses

and in 1646, a law provided that,

> For prevention and redress of many misdemeanours and evil practices, dayly increasing, It is Ordered, That there shall be an house of Correction provided in each County.

With the growth in population, it became necessary to make institutional provision for the needy and almshouses came into being. The Philadelphia General Hospital (or "Blockley," as it was familiarly known) had its origin in the Philadelphia Almshouse, erected in 1732, and had an infirmary or hospital for the sick and insane at that time. Bellevue Hospital in New York traces its origin to the Poor House of the City of New York, established in 1736 "to house the poor, aged, insane and disreputable." Private citizens of Boston, as early as 1658, showed an interest in providing for the poor and made contributions and left legacies for that purpose. In 1660 the selectmen were ordered to erect an almshouse, but no action seems to have been taken until 1662, when an almshouse was built. This was burned and rebuilding was authorized in 1682. It was still unfinished in 1686, but a bill against the town for supplies for the almshouse shows that "it was lighted in 1703 by candles supplied by the father of Benjamin Franklin." A "bridewell" was erected not long after 1712 and a contagious hospital and workhouse in 1738. A charter was granted the Pennsylvania Hospital in 1751, the working plans for the erection of a building were approved in 1755, and by 1756 the building was occupied. This, perhaps owing to the genius of Benjamin Franklin, seems to have been the first general hospital where the insane were received. They were housed in 4 cells in the basement. There were military hospitals during the French and Indian Wars. The Eastern Lunatic Asylum at Williamsburg, Virginia, the first hospital for the insane, was opened in 1773. There were smallpox hospitals or pesthouses and inoculation hospitals prior to the American Revolution.

Individuals and communities made special

provision for the care of particular cases. "Town officers were often charged with the duty of maintaining the mildly insane in their homes. Thus, the colony of New Haven in 1645 made provision for distracted Goodwife Lampson 'so far forth as her husband is not able to do it,' and committed her to the care of the town marshal . . . . The General Assembly of Connecticut Colony as late as 1756 ordered the selectmen of Wallingford to clothe an insane woman and to commit her to the care of 'some discreet person that she may labour for her support.'"

The first prison was built in Newport, Rhode Island, prior to 1648 and used by the Colony thereafter. In 1702 a "good and sufficient" jail was ordered to be completed in Newport, and in 1705 Providence was authorized to build a jail to replace the one that was burnt. The first jail apparently built under the authority of the act of 1725 was at South Kingstown. A Court House and Gaol in King's County were started in September 1729 under the direction of Rouse Helme and were finished by June 1732. The total cost of the two buildings was £791:2:3. In 1745/6 the Newport Overseers of the Poor were authorized to commit persons to the workhouse, so they must have built one prior to that time. The Providence County workhouse was authorized in 1753 and a special rate levied to defray the expense of building. In 1769 a lottery was authorized to build the North Kingstown workhouse, but in most of the towns the poor were auctioned off to the lowest bidder for their care.

The custom of auctioning off the poor was universal throughout New England until fairly recent times. The Overseers of the Poor of the town of Billerica, Massachusetts, published the following Advertisement concerning the poor in 1820:

We the subscribers, Overseers of the Poor of the town of Billerica, will on Monday, the thirtieth day of October instant receive sealed proposals from any suitable person, who may be disposed to take the whole care of all the Poor, whether in said town or out of it on the lowest terms for three years, to board, clothe and to procure for them all Medical and Surgical aid, to nurse them when sick, if any die to be at all the expense of their funerals; to give bonds to idemnify the town from all expense on account of the poor, their bedding and clothing to be made as good at the end of said term as when the contract was made, all which is to be done to the satisfaction of the Overseers. The undertaker will for his pay receive orders on the town treasurer quarterly, and will have the use of the Poorhouse, with the land attached to it for the said term.

Billerica, October 17, 1820.

Samuel Whiting
John Baldwin
John Crosby

N. B. The Overseers will have liberty to put any State paupers under the care of the undertaker, who shall receive for his pay, whatever sums may be received from the State.

Such auctioning of the poor was typical even after the town had bought an almshouse.

From the above it seems evident that the document herewith reproduced had to do with the first attempt to get institutional care in Rhode Island, if we except the jail, which was largely for temporary care. It is obvious that the incentive for caring for the insane was protection rather than treatment. To date we have been unable to locate Joseph Major, or to find out anything more about his "incogitable deportment." It will be noted that the South Kingstown people, as late as 1724, thought that "evil spirits" had something to do with the matter; also that "Bedlam" had become a noun applied to all institutions; and that the deterrent effect of punishment was expected to control their behavior rather than any medical art.

The note on the back of the page indicates that the House of Deputys merely granted that every town ought to take care of its own "frantick and lunatick people," and because the petition was rejected it did not get into the public records of Rhode Island.

Transcription of Attached Photostat

THE HUMBLE PETITION of the Freemen of South-Kingstown Unto The General Assembly to be holden At Providence In the Colony of Rhod Island &c upon the Last wensday of October, 1724.

The Difficulty that Some of the Inhabitants of This Town have Latly unwillingly undergone by the Incogitable Deportment of one Joseph Major Abusing Some and Affrighting others by his Distraction or Misbehaving himself

At This Conjuncture Brought to our Minds The Sad Misfortunes That have latly hapned in this Colony To the Fatal Cost of Some of our Inocent Neighbours Lives. Who not Long Since have been made the Woefull Spectacle Which unusual Murder Imprinted on them They as we may Say becoming Victims To the Monstrous Rage or Cruelty of

The Humble Petition of the Freemen of South Kingstown unto The General Assembly to be holden at Providence In the Colony of Rhod Island &c upon the Last wenf day of Octobr. 1724.

The Difficully that Some of the Inhabitants of This Town have Latly unwillingly undergone by the Incogitable Deportment of one Joseph Major Abusing some and Affrighting others by his Distraction or misbehaving himself

At This Conjuncture Brought to our Minds The Sad Misfortunes That have Latly happned in this Colony To the Fatal Cost of Some of our Innocent Neighbours Lives. Who not Long Since have been made the Woefull Spectacle Which unusual Murder Imprinted on them They as we may Say becoming Victims To the Monstrous Rage or Crusty of those Who have Either Feigned or Really Acted the Bloody Unreasonable part of Mad Men

But that a Stop be put to the Cources of Such Who through Discontent or other waise Receive into their Vicious or Malicious Minds An Evil Spirit and as it were with Saul of old Let Loose their hands to Mischief Mischief Tho perhaps they May not be without hopes of being Saved or Sheltered by the Habit of Distraction

That Care be taken for the prevention of the Like for the Future

We the Said freemen of South Kingstown afore Said at the howse
of Ichabod Sheffield in a publick Town Meeting in Said Town
of South kingstown on the Twenty fifth Day of August 1724. —
In Said Colony. voted - - - - -
This Their Humble petition be prefered To this General Assembly
This Honnourable Assembly being as the Vivifieing part of this
Colonyes Body politick And So to Convey Comfort to Each Respective tho
Inferiour part of this Corporated Body
Which Imboldeneth Your Humble petitioners Instantly and Earnestly
To pray
That there may be in Some Convenient place in this Colony By the
Wise Direction of this Honnourable General Assembly. A Bedlam
or workhouse Built for the Receptical of the Frantick or Lunatick
or Such as appear So in this Colony
That by the Care and oversight of Some qualified person they
May be In the Intervails of their Lunicy Imployed in Such Imployment
as those Distempered persons may be Capable of
That Each Town in this Colony May have Right to Convey their people
that may be under Such Incogitancy to Said Bedlam or workhouse and
That the whole Charge that May thence arise be at the publick Charge of the
The Colony or Each Town there to Maintain their own Frantick or Lunatick.
Further we are Humbly of opinnion that if Such provision were made it
might awe the Indiscreet (minds) of any So Expecting to be Shrouded Chouse of Corrective
or May be More dreded than a prison of Idleness and Loss
To Conclude we hope and question not but if this our petition be granted in
Time it will prove a greater benefit than we are Now able to Express

Signed Jr. Order by Robt. Hannah
Town Clerke

Refered to the Next Setting of ye Assembly
p Francis Willett Clerke

Jan: 2d
Refered to the Next Setting of ye Assembly
p Willett Clke

To the House of Deputys
Gent:
It is the opinion of this House is that every Town
Town ought to Provide for their own Infantick
and Lunatick People and that this Petition
Rooted out
Voted & past
Wood Richd Ward Clerk

South Kingstown Town
Petition

those who have Either Feigned or Reailly Acted the Bloody Unreasonable part of Mad Men

But that a Stop be put to the Cource of Such Who through Discontent or other waise Receive into their Vicious or Malicious Minds An Evil Spirit and as it were with Saul of old Let Loose their hands to Mischief Tho perhaps they May not be without hopes of being Saved or sheltered by the Habit of Distraction

That Care be taken for the prevention of the Like for the Future We the said freemen of South Kingstown aforesaid at the house of Ichabod Sheffield in a publick Town Meeting in said Town of South Kingstown on the Twenty-fifth Day of August 1724.

In said Colony. Votted

This Their Humble petition be prefered To this General Assembly This Honnourable Assembly being as the Vivifieing part of this Colonyes Body politick And So to Convey Comfort to Each Respective tho Inferiour part of this Corporated Body

Which Imboldeneth Your Humble petitioners Instantly and Earnestly To pray

That there may be in Some Convenient place in this Colony By the Wise Direction of this Honnourable General Assembly A Bedlam or workhouse Built for the Receptical of the Frantick or Lunatick or Such as appear So in this Colony

That by the Care and oversight of Some qualified person they may be In the Intrevails of their Lunicy Imployed in Such Imployment as those Distempered persons may be Capable of

That Each Town in this Colony May have Right to Convey their people that may be under Such Incogitancy to Said Bedlam or workhouse and That the whole Charge that may thence arise be at the publick Charge of The Colony or Each Town there to Maintain their own Frantick or Lunatick. Further we are Humbly of opinnion that if Such provision were made it might awe the Indiscreet Conceits of any So Expecting to be Shrouded A house of Correction May be More dreaded than a prison of Idlenes and Ease

To Conclude we hope and question not but if this our petition be granted in Time it will prove a greater benefit than we are Now able to Express.

Signed and Ordered by Rob[t] Hannah
Town Clerke

Refered to the Next Setting of Assembly
Francis Willett Clerke

Jan. 6th

Refered to the next Setting of Assembly
F. Willett Clerke

To the House of Deputys

Gent:

The opinion of this House is that every Town ought to Provide for their own Frantick and Lunatick People and that this Petition be voted out.

Voted apart
by ord[r]
Rich[d] Ward Record[r]

BIBLIOGRAPHY

1. Boucher, Louis. La Salpêtriere: Son Histoire de 1656 à 1790: Ses Origines et Son Fonctionnement au XVIII[e] Siècle. Paris, 1883.

2. Bru, Paul. Histoire de Bicêtre (Hospice—Prison—Asile). Paris, 1890.

3. Colonial Laws of Massachusetts, Reprinted from the Edition of 1660, with the Supplements to 1672, containing also, The Body of Liberties of 1641. Boston, 1889.

4. Commission on Hospital Care. Hospital Care in the United States. New York: Commonwealth Fund, 1947.

5. Curtin, Roland G. The Philadelphia General Hospital: The Medical History of the Philadelphia Almshouse and Hospital, from their Inception to the Consolidation of the County and City of Philadelphia in 1854. *In* Founders' Week Memorial Volume, ed. by Frederick P. Henry. Philadelphia, 1909.

6. de Saussure, Raymond. Philippe Pinel and the Reform of the Insane Asylums. Ciba Symposia, 11: 1222, 1950.

7. Deutsch, Albert. The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times. New York: Doubleday, Doran & Company, 1937.

8. Garrison, Fielding H. An Introduction to the History of Medicine. 2nd ed. Philadelphia and London: W. B. Saunders Company, 1917.

9. O'Donoghue, Edward Geoffrey. The Story of Bethlehem Hospital From Its Foundation in 1247. London & Leipsic: T. Fisher Unwin, 1914.

10. Packard, Francis R. The Pennsylvania Hospital. *In* Founders' Week Memorial Volume, ed. by Frederic P. Henry. Philadelphia, 1909.

11. Quinn, Mary T., Assistant in Charge of Archives, Department of State, Providence, R. I. Personal communication, April 10, 1946.

12. Records of the Colony of The Massachusetts Bay in New England, Appendix, May 28, 1629.

13. Sellin, Thorsten. Pioneering in Penology: The Amsterdam Houses of Correction in the Sixteenth and Seventeenth Centuries. Philadelphia: University of Pennsylvania Press; London: Humphrey Milford, Oxford University Press, 1944.

14. Winsor, Justin, Ed. The Memorial History of Boston, Including Suffolk County, Massachusetts, 1630-1880. Boston: James R. Osgood & Company, 1881. Vol. II, XLVIII; Vol. III, pp. 246, 256; Vol. IV, pp. 644-645; 656.

NOSTOPATHY—A STUDY OF PATHOGENIC HOMECOMING[1]

RICHARD KARPE, M. D., AND ISIDORE SCHNAP, M. D., HARTFORD, CONN.

In studying the returning soldier we are confronted by a seemingly paradoxical phenomenon. Among the patients of our clinic, we see veterans who had shown a great endurance to the hardships of war and whose psychiatric illness did not become apparent until afterward.

Besides those who can be diagnosed as delayed traumatic neurosis, we find another group who did not break down because of sudden relief from tension but did so because of additional stress imposed upon the individual. William C. Menninger(1) expressed the opinion, "In every instance of these delayed reactions there is very good evidence to believe that there was a specificity for the individual in the final event or situation which served as a precipitating factor." This statement is different from the view expressed by Kardiner(2) in an article on traumatic neurosis of war, "The occurrences of the first symptoms after returning to a peaceful environment are usually more apparent than real."

There certainly are cases where the termination of war, the return home and to a civilian life created a more difficult situation than the inhuman conditions of modern warfare. The psychodynamics of this group is not too well studied in psychiatric literature because of a tendency to blame the war and its attendant hardships for the cause of the mental disturbances in veterans. It may be necessary to overcome some resistance in ourselves to realize that the return home may be the pathogenic agent. After doing this, we are not surprised to learn that the family can create emotional problems leading to psychiatric illnesses, and is not for everyone a place where mental health is assured.

The problem of the "discharge neurosis" was discussed by a multidiscipline study group associated with our clinic, which submitted a report(3) to the International Congress on Mental Health in 1948. Since that report, we have been increasingly impressed with the relationship of psychiatric illness to the return to the home environment. It is known that separation from service may precipitate neurotic reactions because of the breaking off of strong emotional ties. The close attachment to one's unit, fellow soldiers, etc., has been observed to be a bulwark against a psychiatric break. The goal of the average nonprofessional soldier is to return home as soon as he can and we are all aware that one of the most popular slogans was "We want to go home." But, in our group the return to the civilian environment was more threatening than the rigors and uncertainties of combat conditions.

For this study a total of 25 selected cases was studied intensively although this by no means represents the total number of such cases that had already been under treatment at this clinic. Among a representative group of 100 consecutive cases accepted for treatment from November 1949 to September 1950, a total of 7 patients had clear-cut evidence of pathogenic homecoming resulting in psychiatric illness. If this percentage were extended to the large number of psychiatric casualties observed during and following World War II, the result would be a significant number of cases.

The objection may be that, before the etiology is attributed to the specific home of the returnee, an investigation would be needed of the influences of the general condition of the civilian environment, as, for example, the element of economic and social competition, poor housing, demotion in status, etc. We, however, limit ourselves to the study of the specific reactions of the patient to his home.

Among the veterans who became ill when they returned home, we find a diversity of psychiatric diagnoses ranging from anxiety reactions to psychoses, as well as psychosomatic conditions. Likewise, there was found

[1] Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

From the VA Mental Hygiene Clinic, Hartford, Conn.

considerable variety in the structure of the family to which they were returning. For some there was no family to return to, for others the home was exceptionally indulgent and pampering, and yet for others the family unit had undergone important changes in the interim. There is no word descriptive of this condition and the term formerly used, "discharge neurosis," does not apply to this group of cases as it emphasizes the element of separation. As noted previously we are not unmindful that there are many cases that illustrate the problem of the separation neurosis or the illness that can be correlated to the loss of the wartime or military environment. Our study leads us to stress the pathogenic effect of the return home. The words "homesickness" or "nostalgia," which could be fitting terms for what we are presenting, are actually used for the opposite condition. These words do not describe the illness due to the home, but the emotional reaction because of the desire for one's home. To differentiate the sickness attributable to coming home from nostalgia we suggest the word "nostopathy," which is a combination of the Greek word for a return—nostos—with the suffix "pathy" denoting a disease; in other words, an illness on return. A fear of coming home could then be described as "nostophobia" and would include the individuals who solve this problem by actually not returning home. It was possible for some to avoid a psychiatric illness by a change of environment.

Among our patients, some were aware of their fear of returning home and were conscious of it. As one veteran described it: "I began to feel lousy as soon as my unit got word that we were going to return to the States. It was then that I began to have pain in my belly for the first time and on the way back it got worse." There were others who kept putting off the day of return as long as possible and when there was a delay in this they felt better. It is this group who had the opportunity to come back at a certain date, but instead selected an alternative that enabled them to be away longer from their homes. As another veteran stated, "I really did not want to come home. I asked to be assigned to some other outfit which was scheduled to stay longer in the combat area. When this came through I felt much better, but on my return the same feeling came back—of not wanting to be home." However, they had to return and in many of this group the symptoms became aggravated the nearer they approached home. A returning soldier became clinically ill at the time that his ship entered San Francisco harbor and became worse as he traveled east to his home. During the return the clinical picture became more manifest as an actual psychosis with delusions and hallucinations.

At times the men were not conscious of the connection between the return and their symptoms. Some of this group became sick in spite of a great conscious desire to be home. They were glad when they received orders to return and they were unaware of negative reactions to the homecoming. One veteran had wanted to come home and it was not until he had been in the States for about 3 months that he began to feel tense, irritable, and had episodes of depression without any conscious knowledge of their relationship to the underlying strong hostile feelings toward the home situation involving his wife and her parents. He would say over and over again, "I do not know why I became sick. It came on me suddenly. I thought it might be due to changes in the weather. To me it is still a mystery."

A question arises whether any decisive change in their lives would have produced a similar reaction in this group of patients. However, a close study of the cases does not substantiate this assumption and it was observed that there was no adverse effect noted when the individuals in this group changed from a civilian status to military service. The transition from civilian to military life seems to be for the average American soldier a harder task than the seemingly easier one of return to civilian life.

The word "return home" can describe one of 4 different situations. The first involves a home that has remained basically unchanged structurally; the veteran found the same family members, older, perhaps more mature. However, a change would ordinarily be expected in the health and efficiency of those family members during the period of separation. If the returning soldier reacts with psychiatric symptoms to the return to the

relatively unchanged home then we must investigate the meaning of those changes, no matter how slight, or look for the specific pathogenic agent outside of the home conditions. Cases A and C, described later in this report, illustrate this problem of the essentially unchanged home.

In the second catagory belong those homes where marriage, birth, or death changed the composition of the family. The returning soldier had not participated in the family adjustment to the event when it occurred. He is therefore expected to adjust to the change in a much shorter time than the others. Pathological reactions to those changes can be due either to difficulty in adjusting or to delayed emotional reaction to them. An example of an impaired adjustment would be the case where the soldier had become a father during his absence and had to face the new situation of parenthood without having the advantage of gradual adaptation to it that exists for a new father under ordinary conditions.

One veteran was overseas when his wife gave birth to a son. When he returned to the States his son was about a year old. To the patient his child represented a threat, a rival, rather than somebody to be loved and accepted. Under ordinary circumstances there would have been more time for a gradual adjustment and the acute symptoms might have been prevented.

Another example of a delayed reaction would be grief that could not find any expression in participation in the funeral or other mourning rituals, and now, faced with a gap left by that death, the emotional reaction blocked from other outlets may lead to symptoms. We have to differentiate between the lack of opportunity for adequate emotional outlet at the time the particular change happened and the specific meaning that the new situation has for him. For example, the death of a father may put new responsibilities on the veteran as the widow may expect him to take the place of the deceased one in regard to satisfying her economic or emotional needs.

This is aptly illustrated in a case where the father had died when he was overseas in combat. It was not, however, until he was about to be returned to the States that he began to have symptoms of anxiety with physical manifestations. On the way back the symptoms increased in severity. When finally discharged from the service he hesitated to return to his home and meet his mother and older brother. He reacted to the underlying emotional problems by such oral manifestations as drinking, the taking of drugs to the point of intoxication, as well as difficulty in eating and choking sensations. He made an unsuccessful attempt to resolve this by a marriage that was forced upon him. This did not lead to any psychiatric improvement. His war record had been excellent and he had had no anxiety whatsoever in dangerous combat situations. However, he was not adequately able to assume responsibility of being a leader and avoided the opportunity to be trained to be an officer. It was not until he learned of the imminence of his return home that he developed symptoms. The death of the father had altered the home to which he was returning and he reacted to the necessity of taking the place of the father.

The third situation occurred when the soldier became engaged or married and now is faced with the necessity of setting up a home of his own. He does not return to the old home, but must create a new one, which may lead to anxiety. The conflicts in regard to heterosexual development are probably of more importance in the etiology and precipitation of the neurosis than the fears of making a living.

A soldier was expected to marry upon his return home. On the way back he had been depressed without any cause apparent to him. He had committed himself to a course of action that unconsciously he had difficulty in accepting. This marriage finally occurred during his furlough shortly before being discharged. His symptoms were related to the marital situation. Another was a veteran whose neurotic symptoms were definitely increased upon return to his home. There had been pressure upon him by his widowed mother to find a girl, become engaged, and eventually be married. The symptom of sexual impotency was a defense against this decisive step in his life.

The last group, much smaller, is that in which the veteran has no parental or marital home to receive him.

An example is one of our patients whose gastric symptoms led to repeated hospitalizations. The hospital represented a substitute for the missing home. When, during treatment, he was made aware of his unhappy homelessness it was no longer possible for him to use gastrointestinal symptoms as a means to gratify dependency needs. The clinical picture changed from that of an organ neurosis to what may be described as a character problem. It was shown that the neurotic symptoms were an expression of his inability to assume the role of an adult and a defense against passive receptive needs.

Some attempts at explanations are given in the literature. Of these, we shall report on

the views of Deutsch and Benedek. A case similar to our cases A and B is reported by Felix Deutsch(4). It involves a veteran, a passive individual, who had developed a duodenal ulcer upon return home. He concludes that the neurosis following return was due to the fact that both the patient and his wife had "regressed too far during separation." He explains that regression as an extension of a separation neurosis. Consequently the reunion had found both unprepared to face adult life again. It is not clear whether the author felt that the depth of a regression during the separation fully explained maladjustment on return. Temporary regressions during recreational activities, sleep, hospitalizations, and the like are ordinarily normal phenomena and considered rather as a safeguard for mental health than a danger. We must attempt to find additional factors to account for the continuation of the regression mentioned by Deutsch.

An interesting concept is advanced by Therese Benedek(5), who writes of a "trauma of reunion" based on 3 possible conditions. The first is concerned with the enhancement of the original conflict between the various members of the family with its attendant guilt during the separation period. The second is the discrepancy in the returning veteran between the feelings that he expects to experience in himself upon return home and his actual emotions. The third is the possible breakdown of the veteran's adaptability to specific situations so that he is less able to handle problems than he was previously.

In the cases that we could study psychodynamically, we found the following factors: difficulties in assuming mature responsibility, the accentuation of dependency needs, opposition against being infantilized by the home, the revival of sibling rivalry, injuries to self-esteem, the decrease in heterosexuality, the increase in aggressive impulses, feelings of guilt and shame connected with former actions while in the service, conflicts about survival in battle and others.

If we relate these factors to the psychological structure of personality (ego, id, and superego) we find the following: (1) weakness of the ego, (2) conflict with superego and ego-ideal, and (3) difficulties in control of instinctual needs. Ego weakness, or its ramifications, predominated in the cases studied at the clinic.

Illustrative Case Histories

Case A. A 32-year-old man upon his return from overseas became depressed, expressed suicidal thoughts, and it was feared that he might jump overboard. His symptoms began abruptly with the news that his unit would be returning to the States. From that day until first seen in the clinic 3 years later his symptoms continued and consisted of depression, self-pity, irritability, difficulty in concentrating, and pains in the upper abdominal area. There was a marked marital problem and when first seen he was separated from his wife. His marriage had occurred 3 years prior to military service and from the very first was unsatisfactory. The picture was complicated by the birth of a son 2 months prior to his volunteering for active military duty. He had actually gone into service as a means of escaping from an intolerable home situation. While on active duty he had an outstanding record, was not hospitalized, and advanced in rank to a position of authority. His unit had more than the average combat experiences, to which he did not react with signs and symptoms of psychiatric illness. The beginning of the break occurred upon his return home. The history is that he was an only child of parents described as being essentially cold, not too permissive, and with a lack of outward show of affection for each other. Any sign of emotion in this family was discouraged and actually suppressed. At an early age he would react to any marked stress with upper gastrointestinal symptoms. He was an individual who intellectualized, was quite inhibited, not aggressive, and made friends with some difficulty. He was able to complete his professional training, but then had a problem in deciding what he should do. He took only positions where initiative and independence were not essential or required. He had a similiar lack of drive in his heterosexual development. His relationship to his wife was a repetition of his emotional attitude toward mother. The psychoneurosis was precipitated by the necessity of returning home. The psychosomatic symptoms about which he complained were a socially acceptable way of avoiding a mature relationship with his wife and at the same time enabled him to be in the position of an invalid, thereby insuring a child-mother relationship. He would presumably have adjusted well if he had remained in service and away from his family. He is one who functions better as a soldier than as a civilian. This case is an example of the milieu of the military service serving to prevent manifest neurotic illness, at least on a temporary basis.

Case B. This 27-year-old veteran developed epigastric pain with nausea and vomiting while he was overseas in the Pacific Theatre with the Marines in February of 1946. He had previously served throughout many campaigns without any psycho-

somatic symptoms. His complaints began abruptly when he was advised that he would be coming home. His wife had given birth to a son after he had gone overseas. The home to which he was returning changed with the addition of this child. He described his feelings: "I knew that I would have problems at home that maybe I could not handle. In China we lived like kings, but I was afraid that back home it would not be as pleasant." The upper gastrointestinal symptoms became worse the nearer he got to home. After he arrived home he was seen by a physician and a diagnosis was made of duodenal ulcer. About 3 months after his arrival the ulcer perforated and he underwent a major operation. The veteran was an only child and consequently had his own way most of the time. His father was a successful and aggressive businessman, and after the veteran grew up there developed hostility toward the father because he felt that he was not favored by him. His feelings toward his mother were somewhat warmer and he described her as one who was not nervous and who gave him considerable attention. In high school he showed initiative and was considered to be successful; however, after graduation he showed a change in this trait and became more passive. He married in 1939 and at first the relationship was said to have been good. However, when the wife became pregnant there developed considerable maladjustment between them and the patient enlisted without waiting to be drafted. He did very well in service and did not become ill until he was about to return home. He is one who could not assume heterosexual responsibilities. Because of his need to be dependent both at home and in business, he reacted to the new situation at home with gastrointestinal symptoms. Under the increasing pressure of this conflictual situation the symptoms became aggravated to the point of actual physical pathology and finally led to the necessity for surgical intervention.

Case C. This 22-year-old soldier was a prisoner of war in Germany for about 4 months. At the time when the camp was liberated by the advancing Allies, he was able to express his hostility physically toward an enemy prison guard who had abused the prisoners. When the soldier came back to the United States he felt proud of this act occurring at the time of liberation. However, when he related his story to his mother she disapproved firmly of his actions. He felt let down, became depressed and anxious, and it was then that the symptoms became manifest. He showed many symptoms of a delayed combat reaction. However, one of the paramount features of the case was a marked feeling of hostility, especially to people in authority as well as to society in general. He got involved in a minor altercation with the law while driving a vehicle. He wanted to retaliate against the doctor who examined him as well as the judge who had tried him.

During treatment he expressed often the idea that he would like to be in service so that he could have the use of a machine gun and thus be in a position to kill and even to be killed in turn. There appeared to be a decided change in personality of this veteran before and after service. Before he had been a social individual, had many friends, went to church regularly and obeyed his mother, at the same time getting along well with the older brothers and a sister. However, after his return he felt hostile toward his family, refused to go to church, lost most of his friends, had a disregard for the feelings of people, and there was a tendency to act out his drives and needs without regard to the consequences. He had some paranoid thinking in that he felt that there was something or someone after him, especially at night when he was alone. He, however, did not show any frank psychotic symptoms. He became involved in fights with others and showed a relative inability to control aggressive drives and sexual strivings. Return home reminded him of his violation of moral standards.

SUMMARY

The following findings were characteristic of the group we have been studying as illustrating the problem of nostopathy in the returning veteran. The adjustment in the premilitary life was not free from neurotic episodes but they did not lead to disabling results. Many of the homes were described as being cold, and a lack of affection was a frequent complaint of our patients. None of the homes could be described as having a good relationship between the parents and the children, and between the siblings themselves. A better than average adjustment to the rigors of combat conditions was observed in the entire group. It was early noted that nostopathy occurred in those men who had had extensive combat experiences without any early clinically diagnosed breakdowns and who had often exceeded the amount of time spent in combat as contrasted to others in similar circumstances. In other words, the superego control in this special situation was unusually strong, and these men did not give up and request to be returned but rather kept on until they were ordered to return. The severe traumatic experiences the soldiers went through without any demonstrable symptomatology at the time may still have caused damage to their adaptability. We certainly found a history of traumatic war experiences in all our cases. However, only a few showed evidence of traumatic neurosis. The changes in the home situation, including even minor ones, had meaning for the veteran and, if one studied his life history, one could understand how that situation was of pathogenic importance.

The group under investigation is an exception to the usual psychiatric experience that the civilian neurotic individual is a poor military risk. Ordinarily, we would expect that ability to adjust in war would be more or less correlated to civilian adjustment; yet in our group, all functioned much better in war than they did in their civilian lives. The result is that the predictability of psychiatric breakdown in war based on civilian history is made more difficult. It cannot be stressed enough that such individuals may be of great value in the military setting during times of national emergency. It should be our responsibility not to overlook the potential excellent serviceman among the neurotic population.

Pathological reactions to return home are not limited to the veteran returning from war but can also be found among those who return from a long absence due to prolonged hospitalization or imprisonment. Cases have been observed in state hospital work where the patient would do well until the moment that his discharge was contemplated and then without any obvious reason there was a return of his illness. Often it is not recognized that the return home was conceived by the patient as a danger to him. The major difference between the returnee from victorious war and from humiliating institutionalization is the increase or decrease in self-esteem. However, in some of the returning veterans, a sense of guilt predominated and they could therefore not accept any narcissistic reward for their participation in the successful war. A study of our own patients has shown to us the pathogenic significance of the return home as an important factor in their illness.

BIBLIOGRAPHY

1. Menninger, Wm. C. Modern Concepts of War Neuroses. *In* The Year Book of Psychoanalysis. New York, International University Press, 1947.

2. Kardiner, Abram. The Traumatic Neuroses of War. Psychosomatic Medicine—Monograph II and III, National Research Council, Washington, D. C., 1941.

3. Karpe, Marietta, and Nicholson, Doris, eds. Neuroses Associated with Discharge from the Armed Services. Submitted to International Congress on Mental Health, London, 1948.

4. Deutsch, Felix. Applied Psychoanalysis. New York, Grune and Stratton, 1949.

5. Benedek, Therese. Insight and Personality Adjustment. New York, Ronald Press Co., 1948

THE PSYCHIATRIST IN GROUP MEDICAL PRACTICE[1]

J. E. TYLER, M. D., AND TOM R. TURNER, M. D.
Tulsa, Okla.

Group medical practice, which first appeared on the American scene in 1904, has gained increasing momentum as a factor in American medicine during the past 15 years. A group medical clinic, which is established to offer comprehensive diagnostic and therapeutic skills of men representing at least 3 specialties, is able to meet the increasing public demand for specialized medical care. The growth of group medical practice in the United States during the past 10 years has been widely publicized by the press(1) as an answer to the advocates of socialized medicine who feel that medical care in this country is inadequate and requires state intervention.

Growth of Psychiatry in Group Medicine:

The psychiatrist has played a very minor role in the development of group medical practice. In a study made for the United States Public Service by Hunt and Goldstein(2) in 1946, psychiatry had such a minor role that it was not even mentioned. It was not until 1949(3) that the first paper on psychiatry in group practice appeared in the literature. In fact, prior to 1940, only 3 clinics of a group of 112 clinics associated with the National Association of Clinic Managers had psychiatrists on their medical staffs. As shown in Fig. 1, there has been a rapid increase in the number of clinics having psychiatrists associated with their staffs, and today roughly one of every 5 medical clinics has a psychiatrist on the staff. This increase in staff psychiatrists in group clinics is probably a reflection of the fact that 82% of group clinics in existence have shown continued growth since their inception(4). Thus we find an increasing number of larger clinics where psychiatrists are likely to be needed.

Although it is difficult to get an accurate census on group clinics today, Fig. 2 shows the distribution in the United States of 37 clinics known to have psychiatrists in early 1951. This distribution roughly approximates the higher concentration of group clinics in the Midwest and California.

In those general medical and surgical clinics surveyed that had psychiatrists on their staffs, the ratio of psychiatrists to other specialists varied widely from 1 to every 7 physicians as a maximum, to 1 in 27 as a minimum ratio.

Those clinics that have added psychiatrists to their groups have appreciated the value of this move, and the experience of the Springer Clinic illustrates the experience of many other clinics in this regard.

Growth of Psychiatry in Group Clinics, 1940 - 1951.

FIG 1.

Initially, the subject of adding a psychiatrist to this clinic came up in 1945. There was a good deal of doubt in the minds of some members of the group that a psychiatrist would be a valuable addition to the staff. The fact that the psychiatrist, by the very nature of his time-consuming work with individual patients, cannot compete with the surgeon or the busy internist from a financial standpoint, presented a very real economic problem that had to be considered. Because the clinic was interested in offering over-all medical care to its patients it was decided, with some hesitation, to add a psychiatrist to the medical staff. Very rapidly the psychiatrist was overwhelmed with work and it was obvious to the other staff members that he had much to offer in the handling of the psychological and neurological problems arising in all departments of the clinic. As a result of this a second psychiatrist was added to the medical staff in 1949.

Roughly, one-third of the clinics surveyed have added additional psychiatrists to their medical staffs; only 4 of the surveyed clinics

[1] From the Springer Clinic, Tulsa.

without psychiatrists indicated an intention of adding one in the future. This indifference undoubtedly is due to a large extent to the failure of the psychiatrist to make known to his fellow physicians the skills that he can offer in the treatment of sick people. Too long he has held himself aloof from the rest of the medical profession, and too often he has been unwilling to subject himself to the prejudices and resistances of his fellow practitioners to his field. Too often physicians have looked upon the psychiatrist as being an odd person who cares for insane people and dallies with impractical theories, but cannot produce any tangible results in the treatment of sick people. Close association of the psychiatrist with his fellow practitioners in the group medical clinic presents a common meeting ground, where they can develop some understanding and tolerance for each other in their medical problems.

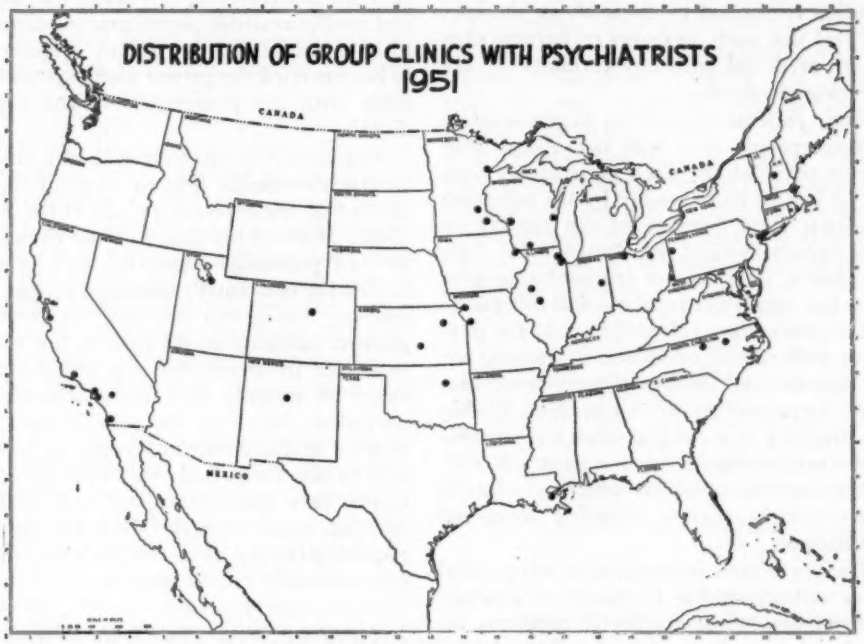


FIG. 2.

Value of the Psychiatrist to the Group:

The value of a psychiatrist to the medical group will vary, depending upon the functions of the group concerned. A few groups have an important role in medical teaching programs. Some of the older and more publicized groups will have a predominant diagnostic function to perform. However, the bulk of group medical clinics in this country are general medical and surgical clinics that have an important therapeutic function in addition to a diagnostic role, and this paper is concerned primarily with the value of the psychiatrist to such a group.

The psychiatrist can, first of all, offer to the medical clinic his diagnostic skills in the evaluation of sick people. His presence increases the likelihood that other members of the group will be more sensitive to psychological factors in the illnesses of their patients. The ready availability of psychiatric consultation increases the likelihood that psychiatric study will be made upon patients with vague and obscure illnesses.

It is felt that every neurotic person, regardless of how poor the outlook seems to the referring physician, should be referred for psychiatric evaluation; and we see many

neurotic patients of long standing who might not be referred except for the ready availability of psychiatric consultation. Many of these patients are not encouraging material for psychiatric help, since they have spent years seeking medical help, going from doctor to doctor, only to become fixed chronic neurotic cripples. However, we have seen a number of patients with illnesses of 2 or 3 decades' duration who were amenable to psychotherapy, and a number of depressions disguised by somatic complaints of long duration responded to electroshock therapy. We feel that such successes or failures cannot be predicted with any certainty by the referring physician.

Many patients referred to us are severely neurotic people who will not accept help from a psychiatrist. Such patients, we feel, can be helped more readily by the referring physician since, because of the rigidity of their personality and the chronicity of their complaints, they are not susceptible to anything but supportive psychological influences. These patients are referred back to the physician with recommendations concerning the management and the superficial psychotherapeutic measures that can be employed. Within the structure of a medical clinic the psychiatrist soon develops a more sympathetic attitude toward the physician who has to handle patients with severely crippling emotional disturbances.

The psychiatric department is being called upon with increasing frequency to evaluate patients presenting diagnostic problems involving primarily subjective complaints. Such patients can be referred to the psychiatrist as a part of the diagnostic work-up. At times a negative psychiatric report prevents the diagnosis of neurosis by exclusion, an error often made by physicians with limited psychiatric knowledge.

A 21-year-old married woman was referred to the clinic as a hysteric, suffering from severe abdominal pain. Previous studies including physical examination, gastro-intestinal and gallbladder examinations had been negative. Psychiatric evaluation, including sodium amytal interviews, revealed that the woman had always handled her emotional problems in a satisfactory manner in the past, and it was felt that there was insufficient evidence of significant psychopathology to justify a diagnosis of hysteria. Further gallbladder studies revealed evidence of numerous shot-sized gallstones that were not visualized on the first x-ray, and following surgical intervention the patient's symptoms were relieved.

A 34-year-old female office worker was referred as a case of globus hystericus, suffering from shortness of breath, weakness, nervousness, crying spells, increasing inability to swallow, and weight loss. Again psychiatric evaluation did not sustain a diagnosis of hysteria, but neurological examination did indicate that the patient was suffering from myasthenia gravis, which responded promptly to treatment.

In these instances it would have been very easy for the referring physician, had he not had readily available psychiatric consultation, to have considered the patient neurotic and to have carried the patient along symptomatically with the progression of the organic disease.

Moreover, the psychiatrist is in a position to give therapeutic help to many of the patients that are referred to him in the group clinic. Much of his time, in those clinics that are not primarily diagnostic, will be spent in treating emotionally disturbed people, thus enabling the group not only to treat the physical ailments of the patient, but to give definitive treatment for the emotional ailments of patients who might otherwise go untreated. Much of the psychiatrist's time is spent in doing psychotherapy, but in addition to this the psychiatrists of many group clinics have general hospital beds available so that more severely disturbed patients requiring the use of electroshock and insulin coma therapy can be treated.

Value of the Group Clinic to the Psychiatrist:

Like the general medical and surgical specialist, who is sensitive to the psychological needs of his patient because of the presence of the psychiatrist, the latter, because of his daily intimate contact with other specialists, is more sensitive to the existence of organic disease syndromes. This tends to prevent his becoming preoccupied with emotional factors in illnesses, which can occur just as easily as the preoccupation with physical disease may occur in other physicians.

The psychiatrist in the group clinic has readily available the diagnostic skills of other specialists to rule out organic disease prior to the undertaking of any psychiatric treatment. In addition, the ready availability

of medical consultation encourages the use of such help during the course of psychiatric treatment.

A 39-year-old married man with hypochondriasis had been complaining of gastro-intestinal symptoms for 3 years and had been under psychiatric treatment for 4 months. Latterly he had an increase in abdominal pain, which he felt was similar to that experienced previously. Because of the increase in pain, medical and surgical consultations were sought, with a diagnosis of acute appendicitis resulting. At surgery this diagnosis was confirmed. Following operation the patient's chronic gastro-intestinal complaints persisted and psychiatric treatment was continued.

The occasional failure of the psychiatrist to recognize such an organic disease syndrome attracts much more attention than the frequent occurrence of unnecessary surgery in patients with functional illnesses.

The group clinic, because of its prestige and the combined opinions of several physicians, often exercises a strong influence on the patient to accept the fact that his illness is of functional origin. This influence is sometimes more powerful than the single opinion of a capable physician and may eliminate some of the resistances patients have to the examination of their emotional lives.

The fact that the psychiatrist is working with other specialists in a group clinic tends to minimize the fears and apprehensions of many people who are advised to seek psychiatric consultation. They are able to see the psychiatrist as one of the clinic, and the emotional turmoil some patients undergo when faced with psychiatric consultation seems to be lessened. The physicians in this clinic have experienced no great difficulty in the referral of such patients.

SUMMARY

1. During the past 10 years there has been a marked increase in the number of psychiatrists in group medical clinics, the number of such clinics having psychiatrists having doubled since 1946.

2. Although there is reluctance on the part of many clinics to add psychiatrists to their medical staffs, the psychiatrist has demonstrated his value to those group clinics with psychiatric departments, as indicated by the fact that one-third of such clinics have shown an increase in the size of this department.

3. The benefits to the patient resulting from the association of a psychiatrist in a group medical clinic are discussed. Such an association enables the psychiatrist and his medical colleagues to utilize the medical skills of each other in offering over-all medical care to the patient.

4. The psychiatrist in the group medical clinic is in an excellent position to counteract some of the negative feelings held by medicine in regard to his specialty and to further the integration of his specialty into the whole of medical practice.

BIBLIOGRAPHY

1. (a) Is this an answer to socialized medicine? Look, **14**: 83, Feb. 14, 1950.
(b) New clinic opened for diagnosis only. N. Y. Times, **99**: 29, Jan. 4, 1950.
(c) Green, P. D., and Cochran, C. 25 doctors for every patient. Coronet, **26**: 162, June 2, 1949.
(d) Heyman, D. M. The health issue: A middle course. N. Y. Times Mag., p. 10, March 6, 1949.
(e) Spencer, S. M. Is the clinic your best bet? Sat. Eve. Post, **219**: 30, March 22, 1947.

2. Hunt, G. H., and Goldstein, M. S. Medical group practice in the United States: III. Report of a questionnaire survey of all listed groups, 1946. J.A.M.A., **135**: 904, Dec. 6, 1947.

3. Stevens, H. Neuropsychiatry in group practice. Am. J. Psychiat., **106**: 292, Oct. 1949.

4. Goldstein, M. D. Medical group practice in the United States: V. Growth of groups. J. Lancet, **69**: 42, Feb. 1949.

THE SERUM BROMIDE TEST AS A ROUTINE

MAX LEVIN, M. D., New York, N. Y.

The quantitative serum bromide test is a powerful aid in psychiatric diagnosis, and I propose to show why it ought to be done routinely in all admissions to acute psychiatric services.

In some hospitals the test is done only on request. The trouble with this is that the physician may not think of asking for it until it's too late. Bromide psychoses are easily overlooked, especially in mental hospitals that are understaffed, where there may not be time to go into the history as carefully as one might like. A patient in a bromide intoxication may be thought to have schizophrenia or some other psychosis. Only when he has made a dramatic and unexpected recovery and then reveals that he had been taking bromide to excess—only then may it occur to the physician that maybe the psychosis was a bromide delirium, but by that time it may be too late for chemical verification. (It's not always too late even then, for the bromide in the blood may outlast the delirium.)

This is not to say that a high serum level always means a bromide psychosis. The level, high though it be, may mean nothing, as in the case of a schizophrenic who has taken bromide to excess but without developing any clinical signs of intoxication superimposed on his schizophrenia. But the fact that the serum bromide level is high will alert the physician.

The practical value of the test is shown by 2 cases.

Case 1. A woman of 45 was admitted to the hospital in a profound delirium, with disorientation for time, place, and person. (A detailed report of this case has already been published(1)). She also showed the neurological and serological signs of dementia paralytica. Knowing nothing else, one might have thought she had advanced dementia paralytica, a disease that, if the patient is not carried off prematurely by intercurrent infection, may end in a terminal delirium, the so-called "paralytic delirium"(2). But the serum bromide level was found to be 350 milligrams percent. We kept our fingers crossed, and 10 days after admission she snapped out of the delirium and came back fully to her senses. Re-examination now showed that her dementia paralytica, far from being advanced, was only in its incipiency.

The patient, one year before admission, had complained of fatigue. Six months later her speech became a little slurred, and she began to take nerve medicine, which she took continuously until admission. One week before admission she became delirious.

Here, then, was a woman who took bromide for the symptoms of an incipient dementia paralytica, and developed a bromide delirium from which she recovered. Without the bromide test one might have been led astray. Suppose, for example, at the height of her delirium she had been given antiluetic treatment. The physician might then have diagnosed an advanced dementia paralytica, with partial remission induced by specific treatment.

Case 2. An unmarried woman of 40 was admitted to the hospital (1932) in a severe paranoid state. The case looked like a paranoid schizophrenia. At 32, after a pelvic operation, she had become run down. A year later she had a hysterectomy and felt better but never regained her former vitality. Two years before admission, owing to the business depression, she lost her job and became moody. A few months before admission she started to take bromide. Eighteen days before admission she became acutely psychotic, and said that men were following her and the State Police were shooting at her through the window. On admission she showed a wealth of delusions and hallucinations. She was well oriented for place and person but occasionally was confused as to time.

The serum bromide level, on the sixth day in hospital, was 325 milligrams percent. Since she had got no bromide in these 6 days, the figure 325 is very high. Still, she looked so much like an "ordinary" schizophrenic that I discounted the bromide report, feeling that the schizophrenia had come first, with bromide intoxication as an unimportant incident. (This was before a clear history had been obtained.)

In her fourth week in hospital the patient astonished everyone by making a complete recovery, and she then gave the history detailed above, which shows that the bromide preceded the schizophrenia. The very high serum level, the time relation of intoxication and psychosis, and the perfect recovery show that the intoxication provoked the schizophrenia.

It has long been known that schizophrenia may start acutely, that in some of these cases with acute onset a toxemia seems to be the precipitating factor, and finally that the acute cases have the best prognosis. In other words, there are transitory schizophrenias produced by toxemias, notably from the

abuse of drugs such as atropine. It was Case 2 that first brought home to me the possibility that bromide too may produce a transitory schizophrenia. In due time 12 more cases of "bromide schizophrenia" came to notice(3).

Case 2 shows the value of the bromide test, without which it would have been most difficult to diagnose the case correctly. An unattractive and frustrated spinster, neurotic for years, grows depressed and then enters a paranoid state in which she thinks men are after her and are shooting at her through the window—such a course of events is a standard item in every textbook of psychiatry. Without the bromide test, and without a really careful history, what is to keep the doctor from diagnosing such a case as an "ordinary" schizophrenia, which, after the unexpected recovery, may be altered to read "schizophrenic episode"? We shall never know how many cases of bromide schizophrenia have gone unrecognized, having been mistaken for "ordinary" schizophrenia, with recovery attributed to rest, or maybe to the extraction of some bad teeth—or to a course of shock treatment that the patient didn't need!

Little or no harm may result from an unnecessary course of penicillin, but the same cannot be said of an unnecessary course of shock treatment, whose normal hazards are not mitigated by pre-existing cerebral disturbance from bromide intoxication.

Since shock treatment is most effective in early cases, the temptation to use it in such cases is great. No acute case, however, should be given this treatment until one has made every effort to rule out a toxic psychosis that would clear up without it.

I submit, in conclusion, that the routine use of the serum bromide test would make for better diagnosis. And, too, it would make for better treatment, in so far as it would tend to avert the use of shock treatment in cases that don't need it.

BIBLIOGRAPHY

1. Levin, M. Bromide psychoses: Diagnosis, treatment and prevention. Ann. Int. Med., 7:709, Dec. 1933.

2. Levin, M. Chronic delirium as a terminal manifestation of organic dementia. J. Nerv. & Ment. Dis., 102:256, Sept. 1945.

3. Levin, M. Transitory schizophrenias produced by bromide intoxication. Am. J. Psychiat., 103:229, Sept. 1946.

CORRESPONDENCE

MUSIC THERAPY

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: The round-table discussion on music therapy at the recent meeting of the A. P. A. in Atlantic City made those who attended it painfully aware of the need for a clear semantic demarcation of the term "music therapy."

The participation of patients of a hospital or institution in group singing, church music, or piano lessons has for a long time been an accepted practice in occupational or recreational therapy. Were this active or passive participation in musical performances a therapy in its own right, one might also speak, in the same sense, of basket-weaving therapy, poetry therapy, and watching-the-world-series therapy. Nobody doubts the beneficial effects of diversion and recreation upon various physical and mental conditions; but this approach should not be mislabeled.

Musical activity can, at best, be only an *adjunct to* a therapy. Psychiatry would profit greatly from a thorough scientific investigation into the basic questions as to *how* music affects the psychophysical apparatus, what factors in the compound "music" influence the compound "psyche," what parts of the latter are affected, in what way and along what pathways this influence is carried. It would be of value to know what individuals can be benefited by music, and what are the indications and contraindications of the use of music as an adjunct to psychotherapy.

If today many hospitals and institutions practice occupational and recreational therapy that include the application of music (or poetry, or art)—we can say: more power to them! No doubt, these methods represent valuable contributions to mental hygiene. But let us keep our signals clear. We must concede that as far as *music* therapy is concerned, we understand but little about its dynamics; have as yet hardly anything to dispense that could be called therapy; and least of all do we know how to train others in applying this form of therapy.

We need more research into the dark field that abounds in variables and unknowns; we need better controls, more exact measuring instruments, and—most of all—patience.

The absence of a clear semantic definition regarding music therapy may prove confusing to the public—not only to psychiatrists and musicians, but also to those who are in need of psychotherapy. Symposia, such as the recent one, may awaken in the public the impression that the A. P. A. endorses music therapy, not as a distant goal well worth striving for, but as a tested and accepted new form of psychotherapy.

The importance of such clarification cannot be overemphasized. While these lines are written, thousands of students in this country are spending their time and money on courses (lasting from 2 to 4 years) that are to prepare them for the new profession of music therapists," that is to say, for the practice of a semimedical profession that as yet does not exist.

EMIL A. GUTHEIL, M.D.,
New York, N. Y.

COMMENT

THE ATLANTIC CITY MEETING

The 108th annual meeting of The American Psychiatric Association was held at Convention Hall, Atlantic City, New Jersey, May 12-16, 1952.

The largest registration in the history of the Association was reported, which totalled 3,459 persons, of whom 1,792 were members and 1,667 nonmembers. In this second year of election of officers by mail vote, of 5,231 eligible voters in the Association, a total of 2,352 votes were cast for officers. The following were elected to the offices of the Association, the candidates having been presented by the Nominating Committee:

Dr. Kenneth E. Appel, President-Elect; Dr. R. Finley Gayle, Jr., Secretary; Dr. Howard W. Potter, Treasurer. The following Councillors were elected: Dr. Henry A. Davidson, Dr. Francis J. Gerty, and Dr. Frank F. Tallman. Dr. C. C. Odom was elected Auditor.

On Monday morning Dr. Leo H. Bartemeier, the retiring President, gave a very thought-stimulating and interesting Presidential address.

On Monday evening at the Claridge Hotel there was a joint meeting of the Atlantic County Association for Mental Health and The American Psychiatric Association, at which several inspiring addresses on mental hygiene were presented, including one by the Honorable Curtis Bok, Presiding Judge of the Court of Common Pleas of Philadelphia, Pa.

On Wednesday morning the annual academic lecture was given by Dr. John C. Whitehorn, our immediate past President. The subject was "The Meaning of Medical Education in our Society." This was a very interesting and challenging address. The discussors of this address were Dr. Erich Lindemann and Dr. Norman Cameron.

On Tuesday the usual luncheon with the introduction of new Fellows of the Association and the presentation of Certificates was held. There were 191 new Fellows accepted in the Association. Two most interesting addresses were given by Dr. Ivan C. Berlien and Dr. George E. Gardner.

On Wednesday evening the usual annual dinner was held at the Claridge Hotel and was attended by about 600 members and guests. The custom established at the previous meeting was continued in that there was no formal address. The Past President's Medal was presented to Dr. Leo H. Bartemeier by Dr. D. Ewen Cameron, the incoming President, and the retiring Officers, Councillors, and Committee Chairman were presented with Certificates of Commendation. Dr. Nolan D. C. Lewis presented the Hofheimer prize to Dr. Robert Arnot, Dr. Milton Greenblatt, and Miss Beatrice Talbot for the research paper entitled "One to Four Year Follow-up of 205 Cases of Bilateral Prefrontal Lobotomy." The Mental Hospital Achievement Award was made as follows: first prize to Dr. S. O. Johnson of the Lakin (West Virginia) State Hospital for an essay entitled "The Making of a Hospital—New Concepts and New Personalities"; second prize to Dr. R. C. Rowell of the Austin (Texas) State Hospital for an essay on "A Plan for Improvement Which Transformed the Senile Wards"; third prize to Dr. J. T. Naramore of the Larned (Kansas) State Hospital for "The Development of a Full Occupational and Recreational Therapy Department." Honorable Mention was made to Dr. Jess V. Cohn of the Embreeville (Pennsylvania) State Hospital for "Change-Over From a Custodial Institution to a Modern Treatment Hospital"; to Dr. Harry J. Worthing of the Pilgrim (New York) State Hospital for introducing chemical treatment of sheets to prevent urinary lesions and odors; and to Dr. H. B. Knowles of the Peoria (Illinois) State Hospital for the establishment of the first separate facility for the treatment of mentally ill children.

A number of most interesting round tables were held this year, and attended by a larger number of members and guests, than usual.

Mrs. Werner Hamburger was Chairman

and Mrs. G. Ruffin Stamps acted as Co-Chairman of the Ladies' Committee on Arrangements, which provided delightful entertainment for the 600 ladies who were present and registered. A "Get Acquainted" tea was given on Monday at the Claridge Hotel and on Tuesday a luncheon was held in honor of the wife of the President of The American Psychiatric Association, Mrs. Leo H. Bartemeier, in the Ocean Dining Room at the Claridge Hotel. The luncheon was followed by a fashion show.

On Friday morning at the business session Dr. Leo H. Bartemeier presented the gavel of the Association to the incoming President, Dr. D. Ewen Cameron, at which time he assumed the Presidency of The American Psychiatric Association.

The Council elected as members of the Executive Committee Dr. William B. Terhune and Dr. Frank J. Curran.

Many important actions of Council were approved by the membership during business sessions. The following are of special interest:

It was voted to hold the next annual meeting at the Statler Hotel in Los Angeles, May 4-9, 1953, and the 1954 annual meeting in St. Louis, Missouri, May 3-7, and Council approved a plan of rotation of areas for the annual meetings as follows: In a 5-year period, the meeting would be held in 2 cities in the East, the other 3 in the Mid-West or Far-West.

There was established the Isaac Ray Lectureship Award for a period of 10 years with approximately $1,400 in the treasury earmarked for this purpose and an anonymous gift of $9,000. This award is to be given by a Committee of 5 Fellows and 2 consulting members from the legal profession to the physician or attorney who, in their judgment, contributed most to the improvement of the relations of law and psychiatry. The recipient of the Award will deliver within the year not less than 3 lectures at some university having both a school of medicine and a school of law. The Award of $1,000 was made this year, and presented at the annual banquet, to Dr. Winfred Overholser.

The New Jersey Neuropsychiatric Association, the Brooklyn Psychiatric Society, and the Michigan Society of Neurology and Psychiatry were accepted as District-Branch Societies, and the Intermountain Psychiatric Association as an Affiliate Society of the A. P. A.

A Committee to Study the Matter of a Permanent Home for the Association was established. This Committee is to study the advantages and disadvantages of the various sites proposed and to bring a report to Council keeping in mind the expressed wishes of the membership in its advisory vote.

It was approved in principle that there be established an Office of a Medical Assistant to the Medical Director for the purpose of expanding the field and other services, and the Budget Committee was requested to consider this additional expense and report to Council.

It was decided that Council should appoint one of its members to work with the Board of Tellers, the Secretary, and the Executive Assistant with regard to the mailing of ballots, and voted to recommend to the Nominating Committee that it submit nominations for officers and Council before August 25 for publication in the Newsletter and the JOURNAL so that the membership may have ample time to submit nominations by petition if they so desire.

It was voted that a Commission of not more than 10 members be set up for a period of 5 years to consider long-term policies of the Association.

Dr. William Malamud was nominated to represent the A.P.A. on the American Board of Psychiatry and Neurology. Dr. Walter E. Barton was elected a member of Council to fill the unexpired term of Dr. J. Fremont Bateman, who died in March 1952. Dr. John D. Griffin of Toronto, Canada, was appointed to the Nominating Committee, and Dr. Lawson G. Lowrey was appointed a member of the editorial board of the AMERICAN JOURNAL OF PSYCHIATRY.

Mr. Franklin B. Kirkbride of New York City was appointed as Investment Advisor to the Association, and on his recommendation a General Investment Fund was set up, which will be outlined in detail in a later issue of the JOURNAL.

It was voted to publish the Membership List yearly and to make a small charge to each member for it.

Of the 15 proposals for amendments to the Constitution submitted to the member-

ship by mail ballot, the first 8 proposals were defeated and the last 7 were carried.

The Committee on Arrangements, under the Chairmanship of Dr. George W. Smeltz, did an outstanding piece of work and the meeting was a most successful one. Dr. Smeltz's Committee was composed of a number of physicians from the Philadelphia and New Jersey area, and he had the very helpful advice of Dr. Ivan C. Berlien, who was Chairman of this Committee at the Detroit meeting, and Dr. Thomas A. Ratliff, who served in that capacity at the Cincinnati meeting.

The technical details, hotel arrangements, eating places, and similar facilities were arranged most successfully as usual by the Executive Assistant, Mr. Austin M. Davies, and the Association expressed its gratitude in resolutions to Mr. Davies, the Committee on Arrangements, the Ladies' Committee on Entertainment, and Dr. David A. Young and his Committee for the very excellent program.

R. FINLEY GAYLE, JR., M.D.

TWENTY-FIVE YEARS OF MENTAL HEALTH SERVICE AT YALE

Since the end of the first World War this country has made distinctive contributions to psychiatric thought and practice. Of these perhaps none is of more interest than the identification as a distinct clinical field of the emotional stresses and strains of the age period referred to as late adolescence or young adulthood. A valuable and informative report, issued by Yale University, puts the psychiatry of the young adult into a stimulating and challenging perspective. It describes the study and treatment of the emotional problems of the young men in the course of their college and university experience. The report, entitled "Retrospect and Prospect," is at once a review of an unusually successful experience, and an exciting program for its expansion, both clinically and in research and training. Yale was one of the first universities to undertake a program of this kind. It is the only university to have maintained such a program without interruption for so long a period. The Yale Division of Student Mental Hygiene is thus more than a pioneer venture. It has now become an established center for the treatment and study of the psychosocial problems of the young male adult in the college setting.

The psychiatrist in a university society has needed to work slowly and carefully, taking into account at every step the particular problems of social structuring, and the characteristic manifestations of interaction between college environment and the emotional needs of the students. The psychiatrist at Yale has been especially fortunate in the wholehearted and continuous support he has been given by the university administration and faculty. The program has also been facilitated, and indeed has been made possible in its present form, by foundation support. The Commonwealth Fund helped initiate a full-scale experiment at Yale. In the course of years the psychiatrist became an accepted part of university society, and the work received recognition with the presentation of a large endowment from the Old Dominion Foundation, which is enabling it to grow in directions that have shown themselves to be the most fruitful and promising in the light of the 25 years' experience. What has come out of the Yale development is the recognition that the period of young adulthood is normally one of complicated growth problems, not all of which can be fruitfully worked out without specialized assistance. The assistance seems best given by people whose training makes available the techniques and knowledge of several fields, notably those of medicine, psychiatry, psychology, sociology, and anthropology.

The history of the Yale experience and the vision of its future is largely the projection of the imagination, insight, and warmth of its central figure and director, Dr. Clements C. Fry. From the beginning of his career at Yale in 1926 Dr. Fry has worked to develop a clinical attitude that looks on the patient not as a diagnostic entity to be labelled but primarily as a sick person to be treated. With Dr. Fry, treatment has always meant understanding, valuing, and helping a human being in difficulty as he is growing up—groping, thwarted, suffering, and hoping.

The sights are set high for the future. We have strong reason to expect that the work at Yale will carry forward into new ground a development that has already made an interesting contribution to psychiatric knowledge and understanding.

RUSSIAN PURGES IN PSYCHIATRY

World War II artificially brought together for the intended goal of mutual survival the USSR and the USA. These two countries had neither a common tradition nor an understanding one of the other. After the war Russia suddenly emerged in the position of a world power unprecedented in her history, and the USA found itself confronted with world responsibilities it had never before faced.

Now Russia finds herself concerned not so much with a world of capitalists *vs.* the proletariat but a divided world led on the one side by the USA awake to the potentialities of the Russian power. Russia's reaction to this has been an intensified nationalism and isolationism that has reached into scientific fields that had not previously been touched by Russian Marxism.

Russian nationalism has been growing for a number of years at the expense of the old brand of Russian Bolshevik internationalism. This trend has been accentuated especially by the controversy with Trotsky and later by world conflicts. One of the first reflections in science of this growth of nationalism was seen in genetics in the now familiar Lysenko-Vavilov dispute. Although there were sporadic attempts to create a "Marxian" science, these were not systematic nor vigorously pushed in physiology and medicine until quite recently.

The effect of this intense nationalism in psychiatry has been, first, a campaign against Western influences, and second an elevation of certain Russian scientists as unassailable authorities. Thus psychoanalysis, which for many reasons was not acceptable in the Soviet culture, had been discredited there even before World War II. Since the War there has been a further systematic effort to purge certain biological sciences including physiology, pathology, and psychiatry of Western influences (described as "capitalistic," "decadent democratic," "fascist") and to set up some past Russian scientists as nearly infallible heroes. Thus Pavlov has now become the standard for Russian physiology and medicine very much as Aristotle was for science in the Middle Ages.

Pavlov always occupied a unique place in Soviet Russia in spite of his frequent diatribes against politics.[1] After his death in 1936 his science as he left it became a standard and a model, and after World War II, what was judged by the authorities to be a deviation from Pavlov's science was condemned. In June and July 1950 a Pavlovian Conference [2] was held in Moscow at which the physiologist Bykov and the psychiatrist Ivanov-Smolensky spoke. Bykov, himself, one of Pavlov's most eminent followers, has probably added more than any other physiologist to this field. Gilyarovsky, a leading psychiatrist, attempted to explain leucotomy, ECT, and electro-narcosis on the basis of Pavlovian protective inhibition. Psychosomatic medicine was criticized as neglecting the social environment in disease and as illustrating idealistic speculations; Freudianism for its "mystical concepts reflecting the disintegration of bourgeois society." Luria, a psychologist, had been severely reprimanded some years ago because of his leaning toward Freud.

On 15 October 1951 it was reported in the *New York Times* that at a joint session of the All-Union Society for Neuropathology and Psychiatry and of the Soviet Academy of Medicine, Gilyarovsky, Gurevich, and several other important psychiatrists were criticized for not adhering to Pavlovian doctrines, or for relating their teaching to American behaviorism, or even for supporting the theories of the Russian neuropsychiatrist Bekhterev, who was during his life

[1] Pavlov, I. P. Lectures on Conditioned Reflexes. pp. 11-31. (New York: International Publishers, 1928.) Conditioned Reflexes and Psychiatry. pp. 11-35. (New York: International Publishers, 1941.)

[2] An excellent and extraordinarily well-balanced account of the Pavlov 1950 Conference has been given in English by Dr. W. W. Gordon, in *Glasgow Soviet Studies*, 1951.

(he died in 1927) in favor with the Soviet Government.

Psychiatric procedures (leucotomy, ECT) must be interpreted in the terms of sleep and internal inhibition. (According to Dr. Walter Freeman, prefrontal lobotomy was in 1951 officially banned.)

Many psychiatrists in the West would agree with some of the critical remarks against certain current physiological and psychiatric theories. The work of some of the people who have been discredited in Russia has also been criticised on this side of the Atlantic; for example the views of Orbeli on the sympathetic nervous system, the work of Lena Stern, and the use of leucotomy. The chief difference is in the vehemence of the Russian criticism, the relationship of the criticism to Marxism and politics, the relative seriousness in Soviet Russia of criticism indicating a "deviation" from the party line, and the basing of the adverse judgment on the interpreted concepts of a deceased Russian hero. Most non-Marxist scientists would also be concerned with the basis of the Russian denunciations. A scientific inconsistency is seen especially in the elevation of any scientist to an impregnable position and in the crystallization of his theories so that they cannot be changed after his death. Pavlov, who held that a theory was a temporary structure on which to hang the facts only until new facts made necessary the construction of a new theory, would have been the last to agree with the placing of his theories on a static base, and of course all great scientists have altered their theories to fit new facts rather than the contrary. Witness, for example, Pavlov's own changing ideas about internal inhibition. Pavlov himself was both a Russian patriot and a world scientist, but he never let his love of country interfere with the strict and objective demands of his science. In his "Last Will and Testament to the Youth of Russia," Pavlov had this advice to offer: "Be not overcome by vanity. On account of vanity you will be stubborn where it is necessary to agree; you will refuse useful counsel and friendly help; you will lose your sense of objectivity." [3]

W. Horsley Gantt, M. D.

[3] Conditioned Reflexes and Psychiatry, p. 189. (New York; International Publishers, 1941.)

HOWARD BLAKESLEE

Many members of The American Psychiatric Association who may have visited the Press room during the annual meetings will remember Howard Blakeslee, the genial science editor of the Associated Press, and will regret that he will be seen no more at our gatherings. Insofar as the publicizing of the proceedings of the Association was in his hands we were assured of sound judgment and accurate reporting. It was a distinction for any scientific organization to have Howard Blakeslee report upon its work. His death in his Long Island home on May 2 represents a heavy loss both to science and to scientific journalism.

Mr. Blakeslee had been in newspaper work for half a century and since 1928 had devoted himself exclusively to science reporting. In this field he displayed such skill as to merit the confidence and respect of scientific workers everywhere in a measure rarely reached by a layman. His stature as an interpreter of science is evidenced by the honors he received. They were many and included the Pulitzer Prize for Reporting, the George Westinghouse Science Writing Award by the American Association for the Advancement of Science, election to the presidency of the National Association of Science Writers, and an honorary Master of Science degree awarded by the University of Michigan in 1935.

The night before his death, Mr. Blakeslee had come from Boston, where he covered the meeting of the American Society of Bacteriologists; ten days earlier he reported the atomic bomb test in Nevada; in 1946 he had covered the atomic bomb tests at Bikini.

Speaking of this great science reporter Mr. Frank J. Starzel, general manager of the Associated Press, said: "The recognition given to him as a layman in scientific circles was unprecedented. His loss to the news profession is great but he will long be a model for reporting in all fields." In this opinion we heartily concur.

NEWS AND NOTES

MENTAL HEALTH CLINICS FOR CHILDREN.—Of 1,228 mental health clinics now operating in the United States, almost 75% are partly or entirely devoted to serving children, according to the Progress Report published by the National Institute of Mental Health. More than half of the clinics are located in the Northeast, a region that contains only about one-quarter of the total population. The ratio of 1.67 clinics per 100,000 population for this region is more than four times that for the southern and approximately 2½ times that for the north central and western regions.

Almost half of all clinics are located in the 106 cities having 100,000 or more inhabitants, but in the northeastern region smaller cities and rural areas are better served than are metropolitan areas in other regions of the country.

About two-thirds of the mental health clinics are operated primarily outside of hospital settings. Less than one-fourth are located in general hospitals and 14% are in mental hospitals. About 11% of the clinics, serving about 9% of the children, reported that they provide diagnosis only; half of these diagnostic centers are located in New Jersey.

SASKATCHEWAN PSYCHIATRIC SERVICES JOURNAL.—Volume I, Number 1, of this new publication is dated April 1952. It is issued by the psychiatric services branch of the Saskatchewan Department of Public Health in the interest particularly of all members of the service in this province. It contains articles mainly by members of various branches of the service and is under the editorial direction of Dr. F. W. Hanley, director of the mental health clinic of Regina General Hospital.

The initial article in this number, titled "Some Historical Aspects of Psychiatric Developments in Saskatchewan," is by Dr. D. G. McKerracher, director of the psychiatric services branch, who has been chiefly responsible for the remarkable developments in the psychiatric field in Saskatchewan during recent years.

PERSONALITY: SYMPOSIA ON TOPICAL ISSUES.—Dr. Werner Wolff is editor-in-chief of this quarterly journal published by Grune & Stratton. Numbers 3 and 4 of Volume 1, dated November 1951, consist of symposia on the topics of hypnosis and personality, and hypnotherapy. Guest editor for these two numbers was Dr. Jerome Schneck. A board of 30 editors is composed of psychologists, anthropologists, etc., in addition to psychiatrists. Annual subscription price for the volume is $6.00.

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE.—Dr. H. Beckett Lang, assistant commissioner of mental hygiene since 1941, retired June 1, 1952, after 28 years in state service. He plans to establish a private practice at Albany Hospital, where he has been on the attending staff as psychiatrist, and will continue his teaching affiliation at Albany Medical College, as associate professor of psychiatry. Prior to his appointment in New York State as assistant commissioner, Dr. Lang served on the medical staff of Willard, Marcy, and Pilgrim state hospitals, and was superintendent of Buffalo State Hospital.

Dr. Charles Buckman, assistant commissioner of mental hygiene since October 1950, has been transferred to Kings Park State Hospital as senior director. Dr. Buckman has been in the state hospital service since 1923. He was director of Gowanda State Hospital from May 1949 until appointed assistant commissioner.

Succeeding Dr. Buckman as assistant commissioner is Dr. James A. Brussel; he will be in charge of the New York City office of the department. From 1940 to 1946 Dr. Brussel served as chief of various neuropsychiatric services in army hospitals, and has in the past year been on leave from Willard State Hospital, where he was assistant director, for army service.

CONTROL OF DRUG ADDICTION.—The third report of the WHO Expert Committee on Drugs Liable to Produce Addiction is now available as No. 57 in the Technical Report Series of the WHO. Referring to the inquiry concerning diacetylmorphine (heroin) circulated to governments by the Director-General of WHO, the report states that there are 50 Member States that have discontinued, or are willing to discontinue, the medical use of this drug. It is considered that the complete abolition of legally produced diacetylmorphine in the world would facilitate the struggle against illicit use of this substance; further steps will be taken in this matter.

Other subjects discussed in the report include the lack of justification for the medical use of cannabis preparations; measures to strengthen control over the barbiturates; control of the use, by addicts, of amphetamine and its methyl derivative.

INTERMOUNTAIN PSYCHIATRIC ASSOCIATION.—This newly established organization was recently accepted as an Affiliate Society of The American Psychiatric Association. It is composed of 30 psychiatrists, 27 of whom are members of the A.P.A. The members of the Society reside in southwestern and northwestern states and the officers are as follows: president, Dr. Jack L. Tedrow; president-elect, Dr. J. O. Cromwell; secretary, Dr. Camilla Anderson; treasurer, Dr. Otto Bendheim.

WESTERN INSTITUTE ON EPILEPSY.—The Fourth Annual Meeting of the Western Institute on Epilepsy will take place in Los Angeles on October 24 and 25. It will be particularly designed for the general practitioner and pediatrician, as well as for public health officials and school personnel interested in the epileptic child and his school and home adjustments.

For further information write to Dr. Jean P. Davis, College of Medicine, University of Utah, 168 Westminster Ave., Salt Lake City, Utah, or Mrs. F. S. Markham, 1100 South Bay Front, Balboa Island, Calif.

CHANGES IN CONSTITUTION AND BY-LAWS

By mail ballot in the spring of 1952, the members of the Association effected 4 changes in the Constitution and 3 changes in the By-Laws. These were announced by the Chairman of the Board of Tellers at the 108th annual meeting in Atlantic City and are now in effect. Members will recall that they received ballots in February carrying 9 proposals for constitutional amendments and 6 for changes in the By-Laws, a total of 15 proposals. Seven of these 15 proposals were approved by the necessary proportion of members. The changes that have been adopted and are now in effect are, in summary, as follows:

CHANGES IN THE CONSTITUTION

Article VII, section 2, was changed by deleting the following phrase: "The Council may appoint an Executive Assistant or a person otherwise designated . . ." and by replacing it with the following: "The Council may appoint such persons as staff, on salary, as in its opinion are needed to administer the activities of the Association."

A new section was added to Article VI to read as follows:

> "A Nominating Committee of five Fellows shall be appointed by the President within one month after his installation in that office."

Article VII, section 6, was changed by providing that "The Council is empowered to adopt a budget for the ensuing year." This replaced the previous phrase, which read "The Council is empowered to adopt a budget for the current expenses of the Treasurer and Committees."

An anachronism in Article VI, section 3, was corrected by providing that the named officers "shall enter upon office at the close of business at the Annual Meeting at which their election was announced," instead of ". . . at which they were elected." (Since they are now elected by mail ballot and not at an annual meeting, the former phrasing was inappropriate.)

Changes in the By-Laws

A new section was added to Article I of the By-Laws to provide for a quorum at Annual Meetings. This reads:

"6. Five percent of the members eligible to vote or 300, whichever number is smaller, shall constitute a quorum for a meeting of members."

Article IV of the By-Laws (Affiliated Societies) was enlarged by adding 2 new sections as follows:

"2. On and after the first day of January 1957, an Affiliated Society shall forfeit its affiliation with this Association if then, or at any time thereafter, fewer than 50 percent of its members are members of The American Psychiatric Association; or if more than 25 percent of its members are not psychiatrists; or if any of its members are not physicians.

"3. On and after the enactment of this paragraph, no society shall be accepted as an Affiliated Society unless (a) all its members are physicians; and (b) unless at least 75 percent of its members are psychiatrists; and (c) unless more than one half of its members are also members in good standing of the American Psychiatric Association."

Article V of the By-Laws (District Branches) was expanded by creating a new body, the Assembly of District Branches. The text of the new section is:

"2. Each District Branch shall select from its membership a representative who shall be elected by the Branch at such time, in such manner, and for such term as the members of the Branch shall determine. These representatives, in the aggregate, shall constitute *The Assembly of District Branches.* The *Assembly* shall meet at the time and place of the Annual Meeting of the Association, at which time, the President or his designate shall convene the meeting. It may meet on its own responsibility at such other time as the representatives shall determine. The *Assembly* shall consider only matters referred to it by Council and shall advise Council thereon. This paragraph shall not be operative until there be eight district branches. The Council shall facilitate the keeping of the records of the annual meeting of the *Assembly.*"

Correct Your Copies

Members are urged to make the above changes in the copies of the 1950 Constitution, which were sent to them. The 1950 edition of the Constitution and By-Laws was printed in full in the August 1950 American Journal of Psychiatry, on page 138. If you retain your Journals, you can readily make these changes by marginal annotations.

Full Text Available

The next issue of the *Membership Directory*[1] will include a full, verbatim text of the current Constitution and By-Laws. A convenient reprint of the amended Constitution and By-Laws may also be obtained from the Executive Assistant at the New York Office, at five cents a copy.

New Proposals

No new proposals for amending the Constitution or By-Laws were filed prior to the opening of the annual meeting, May 12, 1952. There are therefore no proposals to be voted on by mail ballot this year. The Constitution and By-Laws (as amended in May 1952) will necessarily remain unchanged at least until the 1954 annual meeting.

Members and Fellows who wish to suggest amendments will submit petitions prior to April 1, 1953. The procedure is detailed in Article VIII of the Constitution and in Article VI of the By-Laws. Proposals thus submitted by petition will be read at the 1953 annual meeting and voted on in the fall of 1953 or in the early part of 1954 and will become effective (if mail ballot is favorable) at the 1954 annual meeting.

Henry A. Davidson, M. D., *Chairman,*
Committee on Constitution
and By-Laws.

---

[1] The new *Membership Directory* will henceforth be issued annually and will also include the current Constitution and By-Laws. It will be made available to members at the undercost price of $1 a copy. Publication date will be announced in this Journal and in the *News-Letter.*

BOOK REVIEWS

DAS VERSTEHEN UND BEGREIFEN IN DER PSYCHIATRIE. By *Prof. Dr. F. A. Kehrer.* (Stuttgart: Georg Thieme Verlag, 1951.)

This 58-page brochure is a valuable and provocative contribution to the epistemology of psychiatry—a field of inquiry and a discipline far too little cultivated in English and American psychiatry. In this work the author explores the basic functions of "understanding" and "comprehending" in psychiatry. To be oriented to the problem presented by the patient, the psychiatrist must effectively *understand* the nature and quality of the patient's symptoms and disorder. How does the psychiatrist acquire the requisite understanding? Is it not quite often *comprehension* rather than *understanding?* And when the psychiatrist *does* understand, what is it that he encompasses in his understanding—the nature of the condition? its qualities? its causation? the mechanism of its derivation? When the psychiatrist affirms that he knows what is wrong with the patient, what indeed does he know; the *what* of what is wrong, or the *how* of what is wrong? And most important of all, how does the psychiatrist derive his knowledge, and whence?

Dr. Kehrer begins his inquiry by citing Jaspers' classification of the psychosyndromes, under the 3 group headings: (1) the homonomous, (2) the intermediate, and (3) the heteronomous. The *homonomous* are so designated because the symptoms included approximate normal psychological experiences, and are seemingly governed by the same psychological principles as are operative in the state of health. The *heteronomous* on the contrary are totally foreign to normal experience and are associated with the psychopathies, which are seemingly governed by unique psychological principles. The *intermediate* are, as the term implies, those symptoms that have both the familiar and the "unknown" in them.

With this as his point of departure the author explores the numerous ramifications implied in the classification—and he expounds his excursions with great skill and clarity. It is not possible, short of literally translating this work, to do it any justice. It is already too compact to be further abstracted. Yet something of an idea may be gained from a review of the questions he raises. Thus he inquires into the relationship between "understanding" and "explaining" (*erklären*). When one understands a symptom or symptom complex, can one by that token the better explain, or etiologically account for the condition?

More important is the reverse relationship. Does knowledge of etiology contribute to or facilitate the understanding of psychiatric symptomatology? And precisely what is implied in the act or condition of understanding? Does one understand logical derivations, or the rationality of what one beholds and experiences? Does the psychiatrist understand by fathoming the associational relationship in the light of the motivational derivations of the patient's symptoms? Does "teleology," or "goal," afford understanding? What is the psychiatrist's subjective condition: is it empathic? Does he attempt to align his thinking with that of his patient: to be persuaded and to will as he does? What are the confines and limits of understanding, on the part of the one who understands and the one who is to be understood?

The nature of this work should be patent by the token of these few citations. The author's excursions are refreshing and stimulating. They should serve to arouse awareness of how little we do indeed comprehend of the language, of the thought patterns, and of the facile formulae that we employ—all-too-complacently—and how seldom we look at them squarely and searchingly, to ask what *do they* and what *do we* mean.

Kehrer's conclusions are in the main rather pessimistic. Psychiatric understanding and comprehension are in his judgment arts exercised by those natively so gifted. But he discounts their validity as a basis for an objective nosography. One cannot take issue with Kehrer's conclusions, save only by making note of the fact that he rests them entirely on pathology. Psychiatric physiology would, I am sure, prove more understandable and more comprehensible.

IAGO GALDSTON, M. D.,
New York City.

REPORT OF THE GOVERNOR'S STUDY COMMISSION ON THE DEVIATED CRIMINAL SEX OFFENDER. (State of Michigan, 1951.)

The Commission submitting this report included among its members 4 psychiatrists, 2 psychologists, 1 sociologist, 3 clergymen, 3 judges, 2 lawyers, 1 police official, and representatives of mental hygiene, parent-teacher, and interracial organizations. Following the Table of Contents is an unsigned Introduction that is well worth reading. It appears to be a layman's impression of the results of the study. The second paragraph begins with the following: "The Commission used this definition: A person may be considered a sex deviate if his sexual behavior is characterized by repetitive or compulsive acts which indicate a disregard of consequences or the recognized rights of others or if his sexual behavior indicates an inability to manage or control the sex impulses." Although the intent of this definition is clear the wording is rather ambiguous.

The Report itself begins with "Summary and Recommendations." A few quotations from this chapter will serve to indicate the quality and scope of the Report.

"More consideration and study should be given to improving the handling of the victims of sex crimes, particularly children, by the police, pros-

ecuting attorneys, defense counsel and courts, in order to reduce the often-traumatizing effect of the total experience. The inept handling which victims often receive following a sex crime is at the root of much of the reluctance of parents to file complaints. The experience at this stage can be worse than the experience of the crime itself. . . . .

"The Commission recommends the establishment of a specialized procedure for convicted sex offenders, permitting optional indeterminate sentences for a minimum of one day and a maximum of life; treatment of the offenders so sentenced by psychiatric facilities within the Department of Corrections; parole or absolute discharge by the Parole Board; and opportunity for periodic appeals to the courts by the offender for absolute discharge. . . . .

"The Commission would like to see a program of education carried on particularly through churches, parent-teacher organizations, and industrial groups which would smooth the path of former offenders returning to society. . . .

"The Commission recommends that newspapers consider requiring suitable pre-service and in-service training of those members of their staffs who deal with sex crimes in order that they may have a better understanding of the principles of mental hygiene in general, of sex deviation, and of the constructive educational possibilities of a news story. . . . .

"In view of the fact that one in every six or eight of the inmates of Michigan prisons is a sex offender . . . . the Commission recommends that the State invest not less than $50,000 a year for the next five years in a broad program of research by the coordinated social sciences, designed to develop methods for the early discovery of incipient sex deviates, for the improvement of methods of treatment, and for the more effective control of causal factors in families, schools, and communities. To that end, the Commission also recommends the careful accumulation within school systems of records showing the behavior, aptitudes, and traits of the pupils."

The above recommendations probably will receive general approval but the following merit additional comment.

"While more research is needed to identify the exact effect on the reader of the news stories of sex crimes, at the same time the Commission recommends that the press handle such stories with concern for their possibly harmful emotional impact on young readers and on victims of sex offenders."

In a Utopian community no public report of an alleged sex offense or sex offender would be made until a conviction had been obtained. A published accusation of sex offense arouses public condemnation and the alleged offender is thereafter regarded with suspicion and hounded by rumor even though he proves himself to be innocent. It is doubtful whether public welfare is served by the publication of the details of any sex offense. Such publication caters to morbid curiosity and is motivated by commercial interests.

"The programs of the adult and child clinics mentioned in the preceding recommendations should be evaluated at regular intervals, and if it is found that they are not offering services to sex deviates, then a specialized clinic or unit within a clinic should be established for the purpose."

It is well known that with few exceptions psychiatric clinics refuse to treat or do not welcome sex offenders, and it may be necessary to establish special clinics. This is unfortunate because for the welfare of all concerned a sex offender should not be distinguished from other persons with emotional or personality problems. A special clinic imposes stigma upon its patients, it would be avoided by those who shrink from publicity, it would impede frankness and honesty, it might be regarded as another disciplinary agency, and it might become another rendezvous for the exhibitionistic, chronic offender. Few of the present clinics have facilities for dealing with sex offenders. From a therapeutic viewpoint the ideal clinic would have no official connection with the police, the courts, or with penal institutions. It would not disclose the supposedly confidential revelations of its patients unless the patient was a menace to the welfare of the community. It would receive and treat all patients who were in need of treatment regardless of whether or not the problem was obviously sexual. It should offer study and recommendation for first offenders before they are branded for life by police and court records; correctional agencies should avail themselves of this help before a judgment is found.

The remainder of the Report is devoted to "Factual Findings" and it concludes with a "Selected Bibliography" and an Appendix containing numerous graphs and tables. The Report is a product of careful study and well-considered thought on the problem of sex offenders.

GEORGE W. HENRY, M. D.,
Greenwich, Conn.

PROGRESS IN NEUROLOGY AND PSYCHIATRY. Vol. VI. Edited by *E. A. Spiegel, M. D.* (New York: Grune and Stratton, 1951.)

Volume VI of this annual review covers the calendar year of 1950. The editorial goal of this annual is "to develop an always up-to-date encyclopedia of neurology and psychiatry" (Preface Vol. VI, p. v). Remarks of orientation for Volumes I to V may be found in this JOURNAL, Vol. 107, p. 796 (April, 1951).

The editor was assisted by 72 contributors to accomplish the designated goal. It was achieved in very creditable manner. The allotment of space in this 562-page volume is roughly "one third to clinical psychiatry; one third to clinical neurology; one fifth to one sixth to basic sciences; and one seventh to one eighth to neurosurgery." The 105 pages of basic science stand out prominently. In the chapter given to neurology (162 pages), otoneurology and neuro-ophthalmology promptly and favorably arrest attention. Neurosurgery is convincingly presented. The 196 pages of psychiatry are well done. All in all, this volume easily measures up to the earlier volumes and merits frequent use by student and

by physician seeking the "up-to-date" in their professional interests.

THOS. J. HELDT, M. D.,
Henry Ford Hospital,
Detroit, Mich.

MARRIAGE ANALYSIS: Foundations for Successful Family Life. By *Harold T. Christensen.* (New York: Ronald Press, 1950. Price: $4.50.)

Professor Christensen characterizes his book as an "attempt at synthesis, through logical analysis, of some of the core problems of marriage." The approach is functional rather than institutional, and person-centered rather than group-centered. He believes that, if the family is to survive and prosper as a social unit, then society must become more family-minded. Analysis of the principles that underlie success or failure in marriage will, he believes, provide the means by which to eliminate or at least minimize the problems.

The author, who is Chairman of Sociology and Professor in the Department of Family Life at Purdue University, presents his findings in a textbook of some 500 pages, organized for use in college courses in sociology. Much of the material seems to be aimed directly at the students, an orientation that becomes particularly pointed in the "Problems and Projects," concluding each chapter. Here questions are designed to make the student examine his own experiences, opinions, and motives in his associations with the other sex. He is also asked to poll his married friends concerning some aspects of their courtship and marital experiences. One occasionally gets the feeling that the author is endeavoring to provide the student with tools that can lead him directly and early into activities as a marriage counselor.

Factual material and discussion is presented in 14 chapters divided into 4 parts: dimensions, factors, processes, and programs. The major section of the book is devoted to processes; representative examples of the chapters in this part are "Learning to Love," "The Transition into Marriage," and "Growing Old Gracefully."

The point of view is dynamic, in the sense that the effects of one personality upon another, and the influences exerted by social experiences and pressures upon individuals and families, are kept to the fore. However, the deeper emotional effects of parent-child and child-child relationships receive little attention. Statistics are used as a background to highlight the interactions between individuals, and not, as so often seems to happen, as though statistical tables held the answers.

The book has little to offer the experienced psychiatrist, but it does provide an orientation that could be used by premedical students with great profit in their future study and practice. The author makes many points come to life in a way that should facilitate understanding by the physician-in-training of the interaction of social and personal factors in health and disturbances. It might help to dispel some of the biases that impede the acceptance of many socio-psychiatric views on the part of the embryo physician.

L. G. L.

TEXTBOOK OF ABNORMAL PSYCHOLOGY. Revised Edition. By *Carney Landis* and *M. Marjorie Bolles.* (New York: Macmillan, 1950.)

The first edition of this book, which appeared in 1946, seemed to the present reviewer to be the best textbook in abnormal psychology he had seen. This opinion was apparently quite general, since a revised edition was required within 5 years.

The new volume incorporates the recent great advances in medical, social, and biological sciences that have clarified many theories in abnormal psychology. The authors have done an excellent job in presenting in an open-minded fashion many useful facts and theories. Their consideration of all factors—neurological, physiological, psychological, and social—that may enter into the production of abnormal psychological phenomena has resulted in a remarkably well-balanced and unbiased presentation. Contrary to many books in this field, the section on the nervous system is not cluttered up with a lot of elementary histological anatomy, but is concerned with systems that are functionally important and are useful in understanding the abnormal reactions.

The book is divided into 5 sections. Section One, the shortest, provides an introductory *Orientation* toward the field. In Section Two, the *Varieties of Abnormality* are discussed in 15 chapters, covering physical illness and handicaps, the neuroses, the psychoses, epilepsy, mental deficiency, and psychopathic personality. *Explanations* are presented in Section Three, in chapters titled Heredity, Culture and Environment, Development, Internal Environment, Brain. Section Four takes up *Psychopathology* in 6 chapters; while Section Five presents *Diagnosis and Therapy.*

The excellent selection of observations, formulations, and interpretations is based upon a wide range of literature, which is cited in footnotes. Each chapter has an appended list of references and an adequate short summary. Included in the book are many well-chosen illustrations, tables and charts, a glossary, and an adequate index.

The major criticism one may offer of the book is that little is presented regarding children and their problems. One result of this omission is that insufficient attention is given to psychological tests for general intelligence, or to factors (other than rather gross ones) that interfere with learning. Reading disability, fraught with so many consequences for the development of the individual, is not discussed.

As a text on the dynamics of adult abnormal psychology, however, the book leaves little to be desired. It is an excellent addition to the required reading for medical students.

L. G. L.

AN INTRODUCTION TO THERAPEUTIC COUNSELING. By *E. H. Porter, Jr., Ph. D.* (Boston: Houghton Mifflin, 1950. Price: $2.75.)

"This is not an easy book to classify," writes Carl E. Rogers in his introduction to the book. The reviewer agrees with this statement, and even more with another statement in this introduction: "It is not a book to be read straight through." It is rather a book to have available and to consult when problems in counseling arise. While reading it I felt again how difficult it is to draw the line between counseling and psychotherapy, if there is at all a dividing line.

The plan of the book is interesting. The main part consists of a great number of examples of possible counseling situations followed by a multiple choice of replies and reactions the counselor may have. The counseling pretest, as well as the middle and closing phases, is handled this way. Certain special problems and the self-evaluating attitude of the client are discussed. The interview analysis and the counseling posttest are treated in separate chapters. An appendix containing reading sources is added.

The important part is the emphasis throughout the book on the counselor's having to learn about his own attitudes toward the client, particularly how much they are dictated by his, the counselor's, own problems and anxieties. The book is very stimulating and, if one compares it with other textbooks, has the great advantage that it does not tell the student what to do. Rather it forces him to think and to evaluate critically his own attitude, the best choice in a certain situation, and similar factors. It is like college teaching should be: not to tell the students "This is right and that is wrong," but "Think what could be the best reply, do not believe me, the teacher, but criticize, doubt, do your own thinking. All that I, the teacher or the author, can do is to give you a choice of ideas but you have to make the final 'choice." One recognizes that this book addresses itself to a more mature reader and is not suitable for the beginner.

As I felt that reading alone was not enough to give justice to a review of this book, I had a few talks with the vocational counselors in our hospital. I wanted to gain some first-hand impressions from people who not only had read Porter's book, but also would use it in certain real problem situations. Their impression was that its main value consisted in the help the counselor was getting in evaluating his own attitudes and recognizing his own weak and strong points. Certain analysis check lists helped the reader to improve his interviewing and counseling techniques.

Although the author is in favor of nondirective client-centered technique, he gives justice to other possibilities of approach. I believe that this book fulfills a useful purpose in clarifying a great number of problem situations that may arise during the counseling procedure. It assists the counselor in gaining greater maturity and in improving his technique in this field.

BENEDICT NAGLER, M. D.,
McGuire VA Hospital,
Richmond, Va.

STATEMENT ON RACE. By *Ashley Montagu.* (New York: Henry Schuman, 1951. Price: $2.00.)

The "Statement on Race" is an extended discussion of the "UNESCO Statement by Experts on Race Problems." A discussion of the UNESCO Statement is indeed essential. Five drafts of it were checked and rechecked by the 10 appointed committee members and 20 outstanding scientists from all over the world. So compact is the final release (with its 21 condensed paragraphs) that it calls for much amplification. Montagu's discussion also demands careful and thoughtful reading, for it was criticized in manuscript by 11 more scientists.

The material of the book, after having been worked over word by word and sentence by sentence, is extremely well presented, clearly written, and very much to the point. The style, however, is far from journalistic. In tone it is that of the accomplished professor expounding clearly to his students, building up his argument carefully point by point. It is thus a book for the serious reader: one that the university-trained person will enjoy, for it is written in a style familiar to him.

Basically the Statement is a plea for racial cooperation, made with a deliberate effort to save from disaster a contracting world in which people must learn to live together or perish. The scientists explain why all men belong to the same species, *Homo sapiens*; why populations differ in their hereditary particles (genes); why a race is a population, and what a race is not. There are discussions of race-mixture and of human equality. In fact it is a fine book from which to start a good many arguments.

NORMA FORD WALKER, PH. D.,
Department of Zoology,
University of Toronto.

A DOCTOR'S REPORT ON DIANETICS. By *J. A. Winter, M. D.* (New York: Julian Messner, Inc., 1951. Price: $3.50.)

Dr. Winter was the first medical follower of the latter-day healer, L. Ron Hubbard of dianetics fame. In this book Dr. Winter tells how he became involved with Hubbard and how he later came to break with him and branch off to develop his own brand of dianetics. It is his *apologia* to the medical profession as well as an effort to explain scientifically what he feels to be of value in dianetics. It falls somewhat short of the latter goal.

There are 2 aspects of dianetics that are basic and should readily admit of scientific proof or disproof: (1) the human organism is influenced at moments of pain and unconsciousness in such a

way that it may henceforth act uncritically and literally to situations that contain similar stimuli, (2) by recreating these situations in a concrete way they can be erased and their pathological effects eliminated. Winter demonstrates several such situations clinically but fails to give anything resembling convincing scientific proof that the hypotheses are correct. In fact, in spite of his own opinion of his scientific training and ability, he fails to show even that he knows what scientific proof should consist of. He seems quite happy with a couple of detailed recordings of interviews (and even these, he admits, are so edited that the important material of a number of interviews is condensed into one!). However, we need not be too hard on Dr. Winter for this as he has plenty of precedent. A great deal of contemporary psychiatric literature, including most of the psychoanalytic, is of the same tenuous sort.

Hubbard denies that his technique is hypnosis and there is little in his book to confirm the suspicion. However, in Winter's book things are different. It becomes quite clear that he is using positive suggestion as one of his main techniques. In fact Winter's dianetics looks very much like the conventional psychotherapy of the pre-Freudian era.

Winter claims to reserve judgment on the existence of prenatal memories, not seeming to realize that in accepting these productions not as real memories but as fantasies of some sort he is undermining the whole dianetic foundation. If they can be so accepted, so also can those allegedly arising during unconsciousness. However, the author has an alert questioning mind, is sincere, and is apparently not afraid to espouse a new cause if he believes in it. We can well be grateful to him for light on that rare phenomenon we have seen rise and fall before our very eyes—dianetics.

ROBERT E. PECK, M. D.,
New York, N. Y.

TWENTIETH CENTURY MENTAL HYGIENE. By *Maurice J. Shore et al.* (New York: Social Science Publishers, 1950. Price: $6.00.)

This book is not an easy one to review. It must have been difficult to arrange and to edit. In the spirit of its subtitle, "New Directions in Mental Health," it endeavours to symbolize the realism, the challenge, the scope, the scientific outlook, the promise of the mental health movement up-to-date. Eighteen national and international specialists contribute the essays composing its 20 chapters.

There is no preface. The reader must therefore make his own synthesis. This task in itself is challenging, as the following catalogue may reflect.

Chapter I, which is also Part I of a 6-part volume, launches right into an affirmation that the mental hygiene movement addresses itself to human happiness through the development or creation of a sound society. Chapter XX, which is Part VI, demands that the normal individual shall be abnormal, in that he will contribute to the good of all.

Between these two very significant statements, both of which are made by the editor, 17 contributors of note have been asked to discuss topics of importance to the field as a whole. Part II, called Mental Hygiene, contains 5 chapters, as follows: Mental Hygiene and Personality Problems, Mental Hygiene and Pathological Conditions of the Brain, Mental Health Clinics (in U. S.), A Mental Approach to the Physically Disabled, Individual and Group Therapy in Mental Hygiene.

Part III, War and Its Effects, leads off with Edward A. Strecker's "War Psychiatry and its Influence upon Postwar Psychiatry and upon Civilization" (the 17th. Pasteur Lecture); and, of course, this statement is well worth reproducing. It is the only statement previously published. All the other chapters of the book are first-time publications. Part III continues with Mental Hygiene in the Army of Occupation (U. S.), Mental Hygiene of Sex Variants (with government service and national security in mind), Mental Health in Industry, The Contributions of Mental Hygiene and the Future. Part III illustrates the importance of the mental hygiene movement in the governmental affairs of man.

Part IV, Mental Health and Science, includes essays on psychology, psychosomatic medicine, clinical psychology, the Rorschach method, social theory of motivation. It lacks the fullness of a thorough-going social-science approach; but is undoubtedly meant to be symbolic, rather than comprehensive.

PartV, Comparative Mental Hygiene, deals with mental hygiene in Great Britain, in Switzerland, in Latin America. Each essay, here, is carefully done, and reflects hopeful purpose in the movement as a whole.

The reviewer is not competent to assess all the detailed aspects of this book. His feelings are mixed. There is so much, and yet so much unexpressed, in the finished product. We have advanced in the directions set by Clifford Beers. But we need a new kind of leadership, which will be equally all-compelling in the more positive direction of social reform in the interests of mental health. Psychiatry has challenged us through its understanding of the unfit. Social science must go beyond psychiatry, and point up the meaning of social progress in the interests of man.

It is believed that this is the intent of the editor of the volume under review. If so, his book should be a landmark, a turning point in social-science cooperation.

W. LINE, PH. D.
Department of Psychology,
University of Toronto.

PSYCHO-INFANTILISM. By *Bengt J. Lindberg, M. D.* Acta Psychiatrica et Neurologica Supplementum LXI. (Copenhagen: Ejnar Munksgaard, 1950. Price: 7 Swedish crowns.)

This book is a brief review of 30 pyschiatric cases diagnosed as psycho-infantile, together with some discussion of the concept of psycho-infantil-

ism. Lindberg describes psycho-infantilism as a form of "mental weakness" rather than a disease and, although he concludes that it is not necessarily constitutional, he waves back and forth between this point and the possibility of attributing psycho-infantilism to genetic heredity.

The psychiatric orientation of Lindberg follows that of Sjobring's "natural system." Although he originally intended to present extensive case histories, Lindberg decided to present only brief reports that emphasize the features that he calls psycho-infantilism. This apparently results in a one-sided presentation of the case data, which nonetheless suggests, in many instances, that different diagnoses would be made by contemporary American psychiatrists. For example, one case dealt with a cavalry officer who is reminiscent of D. H. Lawrence's *The Prussian Officer*. The diagnosis in this case—alcoholism and hystero-asthenia—illustrates the descriptive rather than dynamic system of Sjobring. Psychoanalytically this case would probably have been diagnosed as showing strong, latent homosexual tendencies, a mother-fixation, and an infantile ego. In reading these cases, the reviewer found them understandable, primarily by transposing the descriptions into terms of American psychiatry. This, however, need not be a serious handicap in reading the monograph.

A more important defect would appear to be the author's failure to distinguish between temperament and character. Much of Lindberg's theoretical struggle appeared to be the result of his not differentiating temperament, the constitutional factor, from the character structure that is superimposed upon that. Once the reviewer was able to clarify this point it became possible to evaluate Lindberg's contributions much more clearly.

Although Lindberg describes all too briefly the treatment given in these cases, one very laudable feature is to be found—that of long-term follow-up. In general, treatment consisted of hospitalization, psychotherapy, foster home placement (in some instances), and outpatient consultation for an indefinite period. One gets the feeling that many of these people will continue to satisfy their dependency needs through outpatient treatment for the rest of their lives. Foster home placement seemed, in some instances, to help to break the great dependencies upon parents and to enable the patients, with continuing treatment and support, to make somewhat more adult adjustments to life situations.

This is an interesting, albeit somewhat too brief, discussion of a class of people frequently seen in psychiatric and medical practice. Generally, such people are characterized as having weak or immature egos, weak character structures, or they may be called hypochondriacs, neurotics, alcoholics, or inadequate people. Lindberg demonstrates that through a well-rounded psychiatric approach most of these people can be helped to salvage more from life than they had been getting, and some can be helped to salvage quite a bit. This monograph represents a challenge to the private practitioner who frequently feels that there is little to be gained in treating these peripheral members of human society.

JOHN D. FOLEY,
Minnesota Psychiatric Institute,
Minneapolis.

THE THRESHHOLD OF THE ABNORMAL—A Basic Survey of Psychopathology. By *Werner Wolff*. (New York: Hermitage House, 1950. Price: $6.50.)

Depending on the needs of the reader, he will find this either an excellent book or a disappointing one. For the beginner in psychiatry, psychology, or social work it is a very complete and accurate survey of the field of psychopathology. The student will find at the end of each chapter an exhaustive bibliography, which might prove to be the most helpful item surveyed by the author.

The views of Werner Wolff on most subjects are sound and the importance of the psychoanalytical contributions are given proper emphasis. There is a commendable tendency to give as many different points of view and theories as feasible in a book of this size and the attempt at being objective is quite successful.

On the other hand, the advanced reader will fail to be satisfied principally because of this attempt at completeness and objectivity. There is not enough on any subject to satisfy the specialist.

The author feels that psychoanalytical concepts furnish the most rational explanation for abnormality to date. This basic belief, coupled with an eclectic, erudite approach and a profound knowledge of Anglo-American, German, Russian, French, Spanish scientific literatures and cultures, makes this book most interesting to read. It is to be recommended to the beginner who wants an accurate bird's-eye view of psychiatry, who wants to know something about subjects as varied as shock therapy, libido theory, Rorschach, hormones and behavior, suggestion and propaganda, psychosurgery, Jung, Adler, hallucinations, drug therapy, psychodrama, cultural patterns, etc.

The bibliography at the end of each chapter is an invitation to go further and satisfy one's deeper needs; it is a remarkable compilation of the relevant literature that will probably satisfy the most discriminating readers.

As stated previously, the advanced reader will find enough in this book to whet his appetite but not enough to satiate it; yet it would be unjust to say that this is a superficial or shallow work or that the specialist could not find in it anything of interest to him.

It is tempting to hold against the author a certain lack of unity that pervades the whole book, but this may well be due to the subject matter under study. The correct conclusion to draw from reading this basic survey of psychopathology by Werner Wolff is that there is no unity in the field of psychopathology and that abnormality is caused by many diverse and complex factors.

Probably college and medical students will be the readers likely to use and profit most by this book.

José Barchilon, M. D.,
Strong Memorial Hospital,
Rochester, New York.

Handwriting Analysis as a Psychodiagnostic Tool; A Study in General and Clinical Graphology. By *Ulrich Sonnemann*. (New York: Grune & Stratton, 1950. Price: $5.00.)

The author attempts to present handwriting analysis both as a practical tool in diagnostic work and as a scientific method contributing to the theory of human behavior. His approach is based essentially on the work of Klages, although Sonnemann modifies Klages' theory under the impact of the contributions of Gestalt theory, of Saudek and Pulver. The presentation of the graphological material is excellent; in the reviewer's opinion there is no better introduction to graphological analysis. The relevance of the method for psychiatric diagnosis is equally well demonstrated. The book suffers—like all contributions in this field—from the inadequacy of the theory of expressive movement; the task of linking handwriting analysis to a more acceptable personality theory has not yet been accomplished. We deplore the fact that most graphological texts attempt to present answers rather than questions. The author seems unduly impressed with the reality of a rather rigid psychiatric classification and pigeonholes human beings and their handwriting accordingly. For the psychiatrist who wishes to become acquainted with handwriting analysis and its potential contribution to psychiatric problems, the book is recommended.

Fredrick C. Redlich, M. D.,
Yale University School of Medicine.

Electroencephalography in Clinical Practice. By *Robert S. Schwab, M.D.* (Philadelphia-London: W. B. Saunders Company, 1951.)

This book, summarizing the clinical uses and limitations of electroencephalography, is primarily intended for clinicians. The reader will find the main topic of the book in Chapters V (EEG in Epilepsy), VI (EEG in Neurological and Neurosurgical Problems), and VII (EEG in Psychiatry). Chapters I to IV deal respectively with historical summary, relation to neurophysiology, the normal and abnormal EEG, and technique. In Chapter VIII, the author outlines some research problems. The concluding chapter deals with laboratory organization, training of staff, and interpretation of records.

Since the book is primarily intended for the neuropsychiatrist and neurosurgeon (and not for the electroencephalographer), the clinical chapters should be considered first. In direct and simple language, Schwab forcibly and convincingly states the case of clinical electroencephalography. Except for some forms of epilepsy, EEG abnormalities are not specific for various neurological conditions. The EEG can never be a diagnostic flag like the Wassermann test. The electroencephalographer can state whether the record is normal or abnormal, if the abnormality is localized, lateralized, diffuse, deep, paroxysmal or continuous; by serial records he can state whether the abnormality is static, regressing, or progressing. However the final diagnosis ("correlative" diagnosis) should not be made on the basis of the tracing alone, but in the light of all the available information concerning the history, the clinical, and the laboratory data. The problem is not whether EEG alone is 90% correct in the diagnosis or only 60%, but whether this procedure is of help to the referring clinician in his final diagnosis. Therefore, the director or the supervisor of the EEG laboratory should be a physician familiar with the neuropsychiatric problems and responsible for the diagnosis. He should work in close association with a physiologist more adequately trained in regard to some specific scientific procedures. The reader will find in these clinical chapters numerous examples illustrating the viewpoint of the author, which could hardly be disputed.

The other chapters of the book are by necessity less developed. One might regret, here and there, unfortunate omissions (for instance, the name of Pravdich-Neminsky was dropped from the history of EEG; the term of "gamma" waves, disregarded); or lack of a more painstaking critical approach to the related material (for instance, in regard to the "loop" theory of rhythmic potentials); or inadequacy of some of the diagrams (for instance, in regard to the amplitude in the "phase reversal technique"); or a somewhat excessive concern regarding practical organizational details (for instance, such fluctuating and unstable data as those related to the budget of the laboratory).

Since the book is mainly addressed to the clinicians to whom such details are of a secondary interest, these inadvertances do not decrease the main value of the work of the author, who should be commended for having successfully introduced, in a proper light, a difficult subject to his clinical colleagues.

W. T. Liberson, M. D., Ph. D.,
Hartford, Conn.

Julius Wagner-Jauregg Lebenserinnerungen. Edited and enlarged by *L. Schönbauer* and *M. Jantsch*. Illustrated. (Vienna: Springer-Verlag, 1950. Price: $2.90.)

Wagner-Jauregg was born in 1857 and died in 1940. During his last year, his activities being severely restricted by a cardiac condition, he had written down from time to time, during hours of enforced quiet, chapters out of his life. These pages were not intended for publication; they were meant for the eyes only of his family and his close professional friends. By accident the manuscript came into the hands of Dr. Schönbauer, who obtained from Wagner-Jauregg's son, Dr. Theodor Wagner-Jauregg, permission to publish. With the collaboration of Dr. Marlene Jantsch he brought together the writings of the great Vienna physician, filling

out the gaps to give continuity to the story and enriching the text with numerous portraits of outstanding physicians of the period, members of the university faculty and of Wagner-Jauregg's staff—Meynert, Krafft-Ebing, Pilcz, Breuer, Freud, Pötzl, von Economo, Marburg, Stransky, Kauders, and others. A number of portraits of Wagner-Jauregg and his family are also included.

In the long scientific life of this many-sided man there were three major interests, forensic medicine, the study of goitre, and the treatment of general paresis.

Before Wagner-Jauregg no psychiatrist had an official seat in the health department. To his surprise he was named to such a post and during his tenure of office (1899-1937) he had the satisfaction of seeing put into effect legislation that elevated the standard of care of the insane and safeguarded their rights. It was a hard 15-year fight. Attacks on psychiatry and psychiatrists had been bitter—a veritable psychiatric witch hunt Wagner-Jauregg called it—but at last the reforms he had fought for were a reality.

A separate chapter titled "Goitre Prophylaxis" gives a detailed account of the author's studies and experimental work on thyroid function, goitre, and cretinism. Then follows the section telling the story of his malaria therapy in general paresis. It should be noted that each of these two clinical chapters is preceded by a useful historical introduction to the subject contributed by the editor. Likewise a brief history (13 pages) of the care of the insane and of laws relating thereto introduces Wagner-Jauregg's account of the struggle for reform.

The charm of this autobiography lies in the intimate and uninhibited way that the author notes down his experience, his relations with his colleagues, the vicissitudes of his pioneer work and the goals he was able to attain. To anyone familiar with the feuds and factions that sometimes appear in scientific bodies and even in university faculties it may be a *Schadenfreude* to read the evidence that Vienna was not immune to these troubles. The author relates, for example, a painful experience in his relations with Freud. The latter had taken umbrage at a harshly critical lecture on psychoanalysis that Wagner-Jauregg's assistant Raimann had given in the International Postgraduate Course for Physicians. Freud, perhaps not unnaturally, blamed the chief for this attack although apparently without justification. He awaited an opportunity for revenge. It came some time later when Wagner-Jauregg was accused by a neurotic soldier of rough methods of treatment. The doctor agreed that his treatment was sometimes "somewhat energetic" but effectual. The Court of Enquiry decided to consult two experts, and Freud and Raimann were named. Freud made a sweeping declaration, reports Wagner-Jauregg, "das recht ungünstig für mich lautete." However, if ill was intended it did not succeed; the accused was exonerated.

There were occasional references in the manuscript to incidents and to persons still living that the editor thought it wise to delete. The author writing for his private record could be blunt in his criticism of intrigue or ill will. Whatever these omissions may have been they have not detracted from a full and lively account of some of the vital developments in recent medical and psychiatric history and of the personality of the chief actor therein.

Wagner-Jauregg had in mind to succeed him as professor of psychiatry in Vienna two men who had served on his staff—Pötzl and von Economo. The latter withdrew his name and Pötzl received the appointment.

C. B. F.

A Study in Alcoholism: Clinical, Social-Psychiatric and Genetic Investigations. By *Curt Amark*. (Copenhagen: Ejnar Munksgaard, 1951.)

Curt Åmark has combined the investigations reported in an international bibliography of over 300 titles with his own research studies on alcoholism. The result is a carefully prepared monograph on the subject with an invaluable collection of historical data on alcoholism interwoven with the results of his own painstaking research on this controversial subject. He has obtained his material from his own psychiatric clinic, the temperance board in Stockholm, and 10 different institutions for alcoholics in Sweden. The material for his research consisted entirely of men together with their parents and siblings.

The historical survey encompasses a wide field and includes many interesting data, including a reference to "the Englishman Trotter (1804)" to whom is ascribed the first written definition of alcoholism as a "disease produced by a remote cause and giving birth to actions and movements in the living body, that disorder the functions of health," which may be the first reference to alcoholism as a sickness.

The aims and results of the research project were reported in the following 5 parts:

1. To examine the siblings and parents of an as far as possible representative material of alcoholics, and to try to determine the morbidity risks for psychoses and psychic abnormalities among them. He concluded that "endogenous psychoses, epilepsy and oligophrenia are of no importance as etiological factors in connection with alcoholism," but "psychopathy is of etiological importance and that genetic factors may conceivably play a role."

2. "To endeavor, taking the material thus obtained as my point of departure, to answer the question as to the role played by hereditary and environmental factors in the origin of alcoholism." As a result of this study, he determined that there might be certain groups in which inherited dispositions played a role in the origin of alcoholism.

3. "To endeavor through analysis of the personality types found among alcoholics and in available comparative materials to ascertain whether certain personality types may conceivably have significance for the origin and development of alcoholism." He felt he had demonstrated that certain personality types predispose the subject for alcoholism. It was

not quite clear to the reviewer how the *prealcoholic* personality had been determined.

4. "To try through a clinical analysis of the material to show whether any special factors affect the clinical picture of alcoholism." His investigations indicated that it takes, on an average, 11 to 12 years for alcoholism to develop from the commencement of abuse to the time of the first official intervention. The latter occurs at about 38 years of age. The author found that periodic alcoholism is connected with, besides genetic factors, the time factor and the personality type.

5. "To try through a comparison of the environmental conditions of the alcoholics with those of the general population to show whether any special environmental situations may conceivably affect the development of alcoholism." He concluded that the childhood and occupational environments had a certain importance for the origin and development of alcoholism.

The methods and procedures of the project are fully outlined in the report. Many of the reported statistics are in confirmation of work previously reported but with more detailed statistical evidence provided. In addition there are some new base lines established for future research studies in the field.

The volume has 283 pages, which are filled with exceedingly valuable material for those interested in the study of the problem of alcohol. The author has made an important contribution to the ultimate understanding of alcoholism.

CURTIS T. PROUT, M. D.,
White Plains, N. Y.

INVESTIGACIONES SOBRE NEUROSIFILIS. By *Dr. Roque Orlando.* (Buenos Aires: Instituto de Investigaciones Neurologicas, Ministerio de Salud Publica de La Nacion, 1951.)

This 173-page monograph is a summary of the investigations and experience of the author over a period of 25 years at the National Neuropsychiatric Hospital in Buenos Aires. A chapter is devoted to each of the following: (1) the Argyll-Robertson pupil; (2) optic atrophy; (3) Erb's spastic paraplegia; (4) the neurological syndromes occurring in general paresis; (5) experience with malaria therapy at the National Hospital (650 cases); and (6) penicillin in general paresis (57 cases, followed 1 year). An effort is made to correlate findings and to show that the A-R pupil, optic atrophy, Erb's spastic paraplegia, and some of the neurological manifestations of general paresis are secondary to toxic effects of the syphilitic aqueous humor and cerebrospinal fluid.

The first 2 chapters are well supported by references to the medical literature. The previous publications of the author are freely drawn upon. The work is reasonably well illustrated with photographs of microscropic sections, tables, and reports of pertinent cases.

In the chapter on the Argyll-Robertson pupil, in addition to a detailed account of the anatomy of the light reflex, the pathological findings in the iris of 7 cases of general paresis are presented. Marked changes of the myelinated fibers of the iris, some with complete loss of myelin, are reported and, since no retrograde degeneration could be demonstrated in the short ciliary nerves, the author concludes that the demyelinization within the iris is the result of toxic effects of the syphilitic aqueous humor. Since, according to the author, the aqueous humor in general paresis shows changes similar to those in the spinal fluid, it is proposed that the changes in the nerves of the iris may be compared with the changes that occur in the central nervous system in neurosyphilis.

It is the author's experience that optic atrophy occurs in 36.2% of cases of general paresis, and he believes that optic atrophy should not necessarily be considered a manifestation of tabes. Malaria therapy combined with penicillin is the treatment recommended for optic atrophy. Erb's spastic paraplegia is presented as a clinical entity with the evolution of a degenerative disease of the pyramidal system, and the author believes it must be considered as a toxic deficiency. Many of the neurological syndromes in general paresis are presented from the same point of view.

The usefulness of malaria therapy is well documented but the author's experience with penicillin was, at the time of writing, admittedly too limited to justify sweeping conclusions.

AUGUSTUS S. ROSE, M. D.,
University of California Medical Center,
Los Angeles.

ANNUAL REPORT ON STRESS, 1951. By *Hans Selye.* (Montreal, Canada: Acta, Inc., 1951.)

This book is published as an appendix, or first annual supplement to "Stress—the Physiology and Pathology of Exposure to Stress, a Treatise Based on the Concept of the General Adaptation Syndrome and the Diseases of Adaptation," by Hans Selye, Acta Inc., Montreal, 1950. It has a similar format, the same excellence of printing and illustration, and the same informal style of the previous volume. In this, and in future annual reports, the author states that he intends to present an extensive classified index of pertinent new facts and a concise, personal evaluation of them. In "Stress" some 5,500 references were cited and in the "Annual Report, 1951," some 3,000 additional papers are listed. Some of these appeared in current journals as late as July and August, 1951. The complete indexing and cross-referencing of this large volume of recent literature is in itself a valuable contribution, and should be of assistance to any but the most casual reader.

The first 50 pages are devoted to a discussion of the general physiology and pathology of stress. The author reviews some of the criticisms that have been levelled at his general theories, at his views on specific diseases, and at his terminology. His replies are interesting and constructive. He acknowledges the stimulation and aid that he and his associates have received from Hench and Kendall, from Reichstein, and from Kuzicka and Collip in the development of their current views. The

word "current" is used advisedly for Selye does not claim that his views have been, or are, static.

The remainder of the book consists of a review of the special physiology and pathology of stress and covers the relationship of "stress" first to the metabolic and then to the anatomic systems.

The reader of this book, whether primarily interested from the point of view of the clinician or the experimentalist, cannot fail to be impressed by the scope of the work, and by Selye's presentation of the results of so many independent investigations within the bounds of a unified theory of medicine.

E. A. Sellers, M. D.,
Department of Physiology,
University of Toronto.

Principles of Abnormal Psychology: The Dynamics of Psychic Illness. Revised Edition. By *A. H. Maslow, Ph.D., and Bela Mittelmann, M.D.* (New York: Harper & Bros., 1951. Price: $5.00.)

The Bases of Human Behavior: A Biologic Approach To Psychiatry. By *Leon J. Saul, M.D.* (Philadelphia: J. B. Lippincott Co., 1951. Price: $4.00.)

Medical Psychology: A Basis For Psychiatry and Clinical Psychology. By *G. K. Yacorzynski, Ph.D.* (New York: Ronald Press, 1951. Price: $6.00.)

Each of these books is designed for use as a text for the basic course in psychobiology in the medical school or for a first-year graduate, or advanced undergraduate, course in abnormal psychology. They certainly differ widely in character.

The Maslow-Mittelmann *Principles of Abnormal Psychology*, proceeding from a psychoanalytic point of view, covers the field fairly well. The introductory section deals with the concept of the abnormal and emphasizes the central role of motivation in psychopathology. Succeeding sections discuss psychodynamics, etiology, and therapy. Concluding sections deal with the "syndromes" of psychopathology. A new feature in this revised edition is a section devoted to behavior disorders in children.

Saul's *Bases of Human Behavior* is more an outline than a text. Again, the central concept is motivation and its effects on physiologic function, tissue change, and behavior. "Psychodynamics" follows an orthodox Freudian pattern. Treatment of topics is summary and rather uncritical. The volume, which is relatively brief (146 pp.), includes an astonishing variety of quotations (Chaucer, Omar Khayyam, Scott Fitzgerald, and many others). This reviewer's feeling was that as a text the book would be relatively ineffective.

Yacorzynski's *Medical Psychology* is written from a broad psychobiologic orientation and makes a valiant attempt to integrate factual data around the concept of *homeostasis*. Part I ("Basic Psychobiological Principles") covers biologic needs, emotion, learning, and motivation. Part II offers a fairly extended discussion of heredity and maturation, and Part III deals with personality development. Throughout there are references to investigation work, including animal experimentation, which provide a factual basis for meaningful discussion. Extensive bibliographies are attached to each chapter.

Together, the Maslow-Mittelmann and the Yacorzynski texts provide a balanced presentation, the one for its excellent clinical approach, the other for its experimental background.

Arthur L. Benton, Ph. D.,
Department of Psychology,
State University of Iowa.

An Introduction to Projective Techniques. Edited by *Harold H. Anderson* and *Gladys Lowe Anderson*. (New York: Prentice-Hall, Inc., 1951.)

This volume is appropriately named. Prepared by 28 contributors, including 4 psychiatrists, it attempts to present in introductory fashion a discussion of those so-called projective techniques upon which a considerable amount of research has been reported. Naturally then, there are introduced not only the more widely known approaches, such as the Rorschach and the TAT, but also others either newer or not so commonly used. These include the Van Lennep Four-Picture Test, word association, sentence completion, the Rosenzweig Picture-Frustration Study, the Bender Visual Motor Gestalt Tests, human figure drawing, finger painting, graphology, expressive movement, the Szondi Test, and several others. These descriptions and evaluations make up the bulk of the book. The latter approaches are stressed relatively in terms of the space devoted to them. For example, despite the 1,500 or so studies on the Rorschach, only 50 pages are devoted to this instrument.

The volume opens with a chapter devoted to a formulation of the nature of human behavior and personality, primarily in terms of principles of growth and conflict, followed by one that is a masterly summary of problems of validation, and lastly a chapter devoted to principles of design in projective instruments. This is followed by the chapters devoted to the techniques previously mentioned. Chapters concerned with the Wechsler-Bellevue and Stanford-Binet, which, although not constructed as projective techniques, are capable of projective interpretation, then follow.

A section of interest to the psychiatrist, quite apart from the major intent of the volume to serve as the introduction to projective techniques, is the last section of the book devoted to projective techniques in therapy. In the first of these four chapters, Adolf G. Woltmann discusses his work and that of Lauretta Bender in the use of puppetry as a projective method in therapy. In the chapter on play as a medium for psychotherapy with children, Joseph Solomon stresses his active approach to the relative neglect of the more passive, free, and spontaneous ways of conceiving this means of interaction. Psychodrama is presented by Haas and Moreno in a fashion familiar to those who know the other writings of the latter. David M. Levy closes the book with a chapter devoted to projective

techniques in interpreting hostility, drawing primarily upon his well-known sibling rivalry studies.

In meeting the major intent, to serve as an introduction to projective techniques, the editors and authors are eminently successful at the level of specific instruments. For this purpose the volume can be enthusiastically recommended. However, this reviewer must admit to a slight disappointment. In the Preface the editors speak of "a consistent conceptual structure or theory of personality and behavior," and go on to point out that this is an essential element in the training and skill in the use of such techniques. Discussion of this matter, although mentioned by the various authorities in connection with specific techniques or in terms of a particular point of view, is nowhere brought into proper common focus. This necessary introductory or closing summary and integration is conspicuously lacking. The Foreword by Henry A. Murray comes nearest to serving this function but of necessity is far too short to do justice either to his conception of the matter or to the topic itself.

ROBERT I. WATSON, PH. D.,
Department of Neuropsychiatry,
Washington University School
of Medicine.

THE PUBLIC HEALTH NURSE AND HER PATIENT. By *Ruth Gilbert, R. N.* (Cambridge: Harvard University Press, 1951.)

The purpose of this book is to suggest the use of a knowledge of human behavior and mental hygiene as "an informed, deliberate, observant method of working, a habit of stopping to think what the behavior of the patient and others may mean in relation to a situation and how the nurse herself relates to it."

There is a long chapter on the teaching of health in general, discussing the use of this approach. This is followed by chapters on the nurse and the maternity patient, the child in his family, and nursing the sick patient. In these there is no attempt to underestimate the importance of sound technical information and technical precision in bedside nursing; but it is emphasized that they must be applied flexibly to the needs of the patient as these become apparent through an understanding of his behavior, and that in themselves they are not enough.

The final chapter discusses relationships with coworkers, dealing first with individual relationships and especially the mental hygiene of supervision, and going on to an analysis of interagency and interprofessional relationships. It is pointed out that the growing knowledge of human behavior and its shared use by several professions has made precise definition of function more difficult. However, there are overlapping and defensive professional attitudes, and an understanding of function is necessary. A very interesting attempt is made therefore to define nursing, and to differentiate it from social work in particular.

The book is well supplied throughout with case history material and illustrations of the use of the principles discussed in actual situations that are met frequently by the public health nurse.

NETTIE FIDLER, R. N.
School of Nursing,
University of Toronto.

PRINCIPLES AND PRACTICE OF THE RORSCHACH PERSONALITY TEST. Second Edition. By *Walter E. R. Mons.* (London: J. B. Lippincott Company, 1951. Price: $4.00.)

In this little book the author discusses briefly nearly all phases of the Rorschach test, including theory, test materials, fundamental procedures of the examination, the importance of observing all details of response (even to attaching special significance to the way in which the subject turns the cards), scoring, and the resultant personality evaluation. In the preface he speaks of 10 years of trial and error with the Rorschach ink blots. When he started he states that he found "that neither standards nor conceptions had any uniformity of character" and "that even within various schools the individual workers permitted themselves a considerable amount of freedom in their definitions and interpretations." For his study he used over 1,000 selected records of children and adolescents from the ages of 4 to 16 years. Half of these were abnormal cases secured from various clinics and agencies, and half of them were normal youngsters from the public schools. The school group was used as a control and half of the children were girls and half were boys, the same as in the abnormal group. These school children were chosen on the grounds of medical fitness and freedom from neurotic traits and had IQ ratings between 90 and 125 on standard tests. The study of these 1,000 records serves as the basis for certain theories and should enable the reader to understand the rationale of the test. This experience with children opened up a better understanding of many adult problems with which the author hopes to deal in another publication.

In his discussion, Mons frequently refers to the adoption of the methods suggested by the Rorschach Institute in the *Rorschach Research Exchange*, edited by Klopfer. He also mentions Oberholzer, Kelly, Tulchin, Harrower-Erickson, Binder, Beck, and other standard references long associated with the use of the Rorschach test.

In this, the second edition, an attempt is made to bring the book up to date by "some additions and minor alterations." However, it is still filled with many trite statements, such as on page 111, "Cooperation and interest in the test are a great help . . . ." The author also states in his preface to the second edition that everyone realizes that ". . . . uniformity of the basic principles of the test has become an absolute necessity." Then he adds, "Once its basic principles have been absorbed its success depends upon knowledge of humanity, and not upon the efficiency of the test material."—Is this then supposed to convince the reader that he is dealing with a standardized test with adequate

validity and reliability? If so, we fear that many persons still will not believe that anyone really qualified to give and to interpret properly a Rorschach need often take the time that is necessary to do so. Furthermore, some of the claims regarding accurate measurements of intelligence and diagnosis are not at all convincing. In regard to using the test for diagnostic purposes, the author states that before trying to make a diagnosis one has to know if the individual is normal or abnormal —a member of the community at large or an inmate of an institution. Otherwise he might make the mistake of a beginner in the field. In such an instance cited by the author the tester was much embarrassed on finding that he had made a "blind" diagnosis and had written "schizophrenic with homicidal tendencies" on the anonymous record of his hospital superintendent. On the basis of this the author recommends that one should never test his friends or colleagues! Aside from these factors he apparently does a good job of handling the details of symbols that have to do with recording and organizing responses, scoring and evaluating them, and interpreting the test results.

E. L. Schott, Ph. D.,
Henry Ford Hospital,
Detroit, Mich.

Psychotherapy. By *Paul Schilder, M. D., Ph. D.* Enlarged and Revised Edition, arranged by Lauretta Bender, M. D. (New York: W. W. Norton & Company, Inc., 1951. Price: $5.00.)

Schilder's pioneer work is here revised by the addition of many articles and excerpts from his later writings. Many annotations by Dr. Bender and a new bibliography have enlarged the book and enhanced its value. Schilder's eclectic attitude, catholic interest, dynamic approach, and his brilliant spirit pervade the work.

Though it was not his intention to write a textbook on psychiatry or present a general theory of the neuroses and to proceed in a symptomatic way with the problem of psychotherapy, Schilder nevertheless begins in his first chapters with the statement of general principles before approaching the problem of technique. The major portion of the book is devoted to details of therapeutic relationships, the various psychotherapeutic systems, the dynamics of group psychotherapy and treatment, specific types of neuroses and psychoses.

That there is no general systematic presentation of an over-all theory from which he proceeds to technical details is both the strength and the weakness of Schilder's book. This weakness lies in his regretably leaving open the many questions about indications for short psychotherapy versus "deep analysis." The reader often gets the impression that any therapeutic technique that works is justified, an implication that Schilder may not have intended to give.

To this reviewer the book's strength lies in its wealth of clinical material. In this day of emphasis on dynamics it has become a little old-fashioned to devote effort to clinical data. Schilder, however, draws continually upon his phenomenally large material with constant reference to dynamics. Hence, the content consists of a weaving back and forth from clinical to dynamic aspects. Valid as this style is pedagogically, it will undoubtedly be a disappointment to inexperienced students and practitioners who seek for the magical short-cut answer of their favorite question, "What do I say next?"

A certain definite amount of both solid theoretical and practical experience is necessary for the fullest comprehension of the book. Only then will the apparent (and possibly real) theoretical looseness and the multiple therapeutic approaches not be confusing. For instance, about anxiety neurosis Schilder writes (p. 263), "It is obvious that at least short psychotherapy . . . . is necessary. Short psychotherapy, in which hypnosis is used, often is successful. A great number of cases need an extended treatment either in group psychotherapy or in analysis." Obviously numerous questions, important ones, are unanswered by such a quasi-pragmatic attitude.

Beginners in psychotherapy will misuse some of Schilder's teachings. Those with good training and aptitude in psychotherapy will profit immeasurably, directly and indirectly, by participating in Schilder's rich and varied therapeutic experiences.

Norman Reider, M. D.,
Mount Zion Hospital,
San Francisco.

Sexual Deviations: A Psychodynamic Approach. By *Louis S. London* and *Frank S. Caprio.* (Washington, D. C.: The Linacre Press, Inc., 1950. Price: $10.00.)

This book is intended as a reference on the subject of sexual deviation. The approach is psychoanalytical, and the authors feel that it fulfills a need for a book in which the emphasis is placed on the psychodynamics rather than the description of sexual deviation.

The book is divided into 3 parts. Part I undertakes a historical survey, psychosexual development of the child, and a brief discussion of the roles played by the homosexual and narcissistic components in sexual deviation. After a discussion of the difficulty in defining sexual deviation in biological and cultural terms, the authors conclude that "if the norm is assumed as heterosexual genital, as Freud indicated, it is so accepted in modern civilization, then every sexual deviation . . . . has the common denominator of (a) substitute gratification; (b) an incompletion or distortion of the sexual process, corresponding to an earlier phase of individual development; (c) concomitant neurotic conflict with the resultant disorganization of the personality in some important respect." With this definition in mind, the authors feel that the problem can be studied as a scientific unity. Then follows a historical account of the prevalence and influence of sexual deviation on ancient and modern culture. Mention is also made of the contributions of the various authors in the field of sexual science. An outline of Freud's theory of the child's psycho-

sexual development and a discussion of the homosexual and narcissistic components of the libido of the adult serve as an introduction to the clinical material in Part II.

Part II is concerned with case presentations of the various sexual deviations and makes up the greater part of the book. The cases are taken from the authors' psychoanalytical practice. Occasionally, the authors use the patients' own psychobiography but the majority of the cases take the form of verbatim material followed by interpretation and comment. There is emphasis on dream material, and in one instance a case is presented from interpretation of the patient's dreams apart from other data, which are later added in the nature of a control. The cases that receive extensive consideration are those of homosexuality, incest, exhibitionism, frottage, sadism and masochism, fetishism, transvestism, coprophilia, urolagnia, and zoophilia. For completeness a group of miscellaneous sexual deviations including coprolalia, pygmalionism, and rape are briefly discussed.

Part III is a general discussion. The thesis that the authors state they have attempted to prove is that sexual deviants are not pathological entities but represent symptoms of underlying neuroses of an obsessional type, that no one is born a sexual deviant, and that all abnormalities of the sex instinct can be traced to some deep-seated neurosis in childhood. They feel that sexual aberrations are more frequent than generally presumed but that many are transitory and brought on by circumstances. The nature and motivation as well as the attitude of the persons involved must be taken into account before the normality or abnormality of the sexual acts is decided. It is noted that many somatic complaints can be traced to underlying sexual pathology. The authors give excerpts from case histories to illustrate their points. As to treatment, it is stated that "psychoanalysis today offers the sexual deviant the greatest hope of lasting cure." Recognition is made of the fact that many sexual deviants do not want treatment. The authors have no ready answer to this problem except to point out the futility of legal prosecution and to stress the need for public education.

To all those concerned with the pressing problem of sexual deviation, the therapeutic approach should prove encouraging. To the legislator and jurist this book offers a timely and authoritative, albeit somewhat technical, guide to a difficult problem. The psychiatrist should find the case presentations interesting, but he will find that the remainder of the book does not maintain the same level of discussion. The authors are fully aware of the book's deficiencies and state "the work is a beginning—not an ending in so vast a field."

JOHN APPLEBY, M. D.,
Colorado Psychopathic Hospital.

MENTAL HEALTH AND HINDU PSYCHOLOGY. By *Swami Akhilananda.* (New York: Harper and Brothers, 1951. Price: $3.50.)

It is the conviction of Swami Akhilananda that Western psychotherapy is at a critical stage in its development and that it can profit now by contact with Hindu psychology, which is essentially concerned with the problem of orientation and integration of the person. One purpose of his book is to offer some suggestions as to the ways in which Indian thought can make contributions to Western psychotherapy. In the main, however, the book is directed to the lay reader who wishes to know what Indian thought has to say about anxiety, fear, aggression, competition, cooperation, conflict, tension, alcoholism, love, the power of mind, and, in general, the role of religion in personal integration. In the discussion of these topics the author makes extensive use of contemporary Western thought, and makes many penetrating remarks concerning Western civilization.

The main thesis of the book is that "egocentricity . . . . is the chief cause of maladjustment in life" (p. 17), that egocentricity can be combatted only by linking oneself with a larger whole (whatever this be called), and that Hindu psychology offers insights and techniques by which the battle against egocentricity can be fought. Swami Akhilananda himself interprets the goal of life in Hindu religious terms, and believes no purely humanistic and naturalistic interpretation is an adequate substitute for religion. But even readers who do not share this conviction will welcome its presentation, and may agree that the release from egocentricity is a central problem of maladjustment, and one that Western thought has hardly begun to explore in the systematic fashion of the Orient.

A preface to the book is written by O. Hobart Mowrer, and the jacket contains recommendations by Edgar S. Brightman, Pitirim A. Sorokin, and Gordon W. Allport. Swami Akhilananda is also the author of *Hindu View of Christ,* and *Hindu Psychology: Its Meaning for the West.*

CHARLES MORRIS, PH. D.,
Department of Philosophy,
University of Chicago.

PRACTICAL CLINICAL PSYCHIATRY. Seventh Edition. By *Edward A. Strecker, Franklin G. Ebaugh,* and *Jack R. Ewalt.* (Philadelphia: Blakiston, 1951.)

Those familiar with the earlier editions of this popular textbook will find that the present edition has been entirely rewritten, condensed, and in many ways "tidied up," so to speak. The word "psychobiological" is now only infrequently met with and the rest of the Meyerian apparatus is far less in evidence: a significant trend. The great increase and complexity of the treatment aspects of psychiatry in recent years have had the effect, possibly an unfortunate one, of a still further compression of the sections on general psychopathology. Here the authors, nevertheless, have managed to maintain a sound, common-sense eclecticism.

As a textbook intended to instruct, not to mystify, *Practical Clinical Psychiatry* continues to be well written and as thorough as one could expect from its modest compass of 498 pages. One advantage of a popular textbook is that it is possible to keep it up to date. Thus the sections on paresis, epilepsy,

and the refinements of shock treatment will be found quite adequate and documented by valuable, concise bibliographies. Especially good are the new sections on psychosomatic medicine and the treatment of psychoneurotics, where practical and well-tested methods are presented for the handling of this large group of patients.

Despite the likely prospects of a wide sale, the book has not succumbed to the easy temptations of popularization, but remains quite solid and a "must" for the active, practicing clinician, for whom it is primarily written.

HIRAM K. JOHNSON, M. D.,
Orangeburg, New York.

RECOVERY FROM APHASIA. By *Joseph M. Wepman, Ph. D.* (New York: The Ronald Press Co., 1951. Price: $4.50.)

This book, addressed to all who treat aphasic patients, is in 3 parts.

A first part defines the nature of aphasia as a dysfunction of any or all of the language modalities. A holistic approach, influenced by Hughlings Jackson, Head, Goldstein, and Lashley, is followed, and nonlanguage characteristics are considered. The influence of activity in the rest of cortical tissues is kept in mind and used in therapy.

A second part is based on a research experience at an American Military Aphasia Centre, 1945-1946. It moves from the author's statement that "many neurologists have held the opinion even in recent years that little can be done for patients suffering from aphasia" to his conclusion that "aphasia following brain injury is amenable to improvement." An analysis of 68 cases is presented. They were young military patients under age 38, with posttraumatic head injuries, who after 6 months were considered to have reached the end of spontaneous recovery. After this "initial" phase an 18-month re-educational training was given to treat the "residual" aphasia. The analysis is interesting and has value for the literature, but I doubt the novelty of the author's proposition. That spontaneous improvement in young people after head injuries may proceed for 2 years and more likely up to 4 or 5 years is the common knowledge of good clinical neurologists even if the literature is not clear on this point. Aphasia at older ages is, of course, less remitting but at any age there may be reward from working with these patients for at least 2 to 5 years. My own clinical impression is that patients gain beyond a spontaneous improvement in almost all neurological rehabilitation when interest, enthusiasm, faith, hope, and success enter their lives. Moreover, with damaged brains as with whole ones, particular functions, including those of communication, are improved by systematic practice under instruction.

The third part of the book is a practical exposition of therapeutic procedures, which should prove useful to the many who, with scant neurological experience, are called on and can do so much to help these patients.

J. ALLAN WALTERS, M. D.,
Toronto General Hospital.

THE 1951 YEAR BOOK OF NEUROLOGY AND PSYCHIATRY. By *Roland P. MacKay, M. D.* (Neurology) and *Nolan D. C. Lewis, M. D.* (Psychiatry). (Chicago: The Year Book Publishers, Inc., 1952. Price: $5.50.)

This year's edition of the Year Book is smaller than last year's by about 75 pages by reason in part of omission of a separate section on neurosurgery. Dr. Percival Bailey, who for the past 5 years has edited this section, was unable to give time for its preparation for the 1951 Year Book. This loss is largely made up, however, by inclusion of some 20 reports on psychosurgery in the section devoted to psychiatry, and reports on other aspects of neurosurgery, e.g., tumors, pain, epilepsy, in the neurology division, which is considerably expanded as compared with last year and occupies nearly two-thirds of the Year Book. By this arrangement, too, a degree of overlapping of the fields has been avoided.

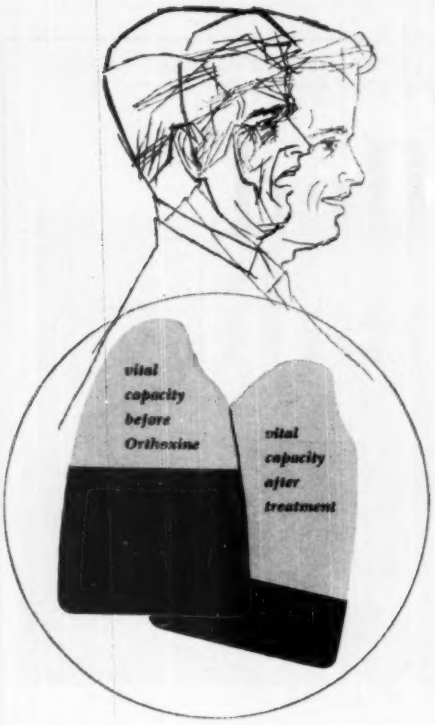
The introduction to the section on neurology by MacKay points out important recent developments and work in progress in that field, with page references to corresponding abstracts. He mentions the increasing interest in the nature of the nerve impulse and in activities at synapses and neuroeffector junctions; the contributions of the new hormones to the study of nerve-muscle chemistry; the changing views on cortical function and localization ("It would appear that the strict localization of cortical functions in a mosaic of anatomically discrete areas must give way to a newer concept of flexible cortical adaptability and integration"); the great role of the antibiotics in the treatment of infective processes in the central organs; new studies on poliomyelitis and on vascular disorders; and particularly the vastly important EEG studies in the epilepsies.

In his introduction to the section on psychiatry Nolan Lewis stresses the importance of genetic and constitutional factors in mental disease, and the increasing scope of biochemical studies and of experimental pharmacology in connection with emotional states. Child psychiatry is getting more attention from pediatricians, and geriatric literature is expanding. The problems of alcoholism and of sex offenses are receiving increased attention. Psychosurgery, in spite of constantly expanding application and reports of predominantly favorable results, is still a controversial subject. Lewis takes a very conservative position.

He pays tribute to the science laboratories and viewing the field as a whole concludes that "the scientific method must constitute the backbone of psychiatry of the present and future."

The Year Book gives a fair sampling of the literature in the two fields and maintains its high reference value.

C. B. F.



an answer to asthma

Q. Is there a sympathomimetic agent that will give relief from asthma without causing vasopressor and psychomotor stimulation?

A. Orthoxine Hydrochloride provides bronchodilatation with minimal vasopressor and psychomotor stimulation. By modifying the configuration of a sympathomimetic amine molecule, the action of Orthoxine has been centered mainly upon bronchodilatation, thereby minimizing side-effects arising from vasopressor or psychomotor-stimulating activity.

Orthoxine*

HYDROCHLORIDE

BRAND OF METHOXYPHENAMINE

Bottles of 100 and 500 tablets.

Orthoxine Hydrochloride (100 mg.) tablets contain *beta-(ortho*-methoxyphenyl)-isopropyl-methylamine hydrochloride, a bronchodilator and antispasmodic.

For Adults: ½ to 1 tablet (50 to 100 mg.)

For Children: half the dose

For Both: Repeat every 3 to 4 hours as required

*Trademark, Reg. U. S. Pat. Off.

Upjohn *Medicine . . . Produced with care . . . Designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

The Brown Schools

For Exceptional Children

Four distinct units making satisfactory placements possible for boys and girls and young adults.

Ideal winter climate affording happy healthful outdoor play and recreation almost every day of the year.

- Daily Neuropsychiatric supervision and guidance.
- Psychological Examination
- Registered Nurses
- Pre-vocational training
- Teachers with degrees
- All academic subjects
- Year round program
- Speech
- Music
- Ranch for older boys
- Home for older girls
- Fireproof building
- Summer Camp

PAUL L. WHITE, M.D., F.A.P.A., ***Medical Director***
M. D. HEATLY, M.D., F.A.C.S., ***Resident Physician***
JESSE VILLAREAL, PH. D.,
Speech Pathologist

BERT P. BROWN, ***President***
Box 4008, Austin, Texas

"URGENT"

* This office would like to obtain by purchase or by gift copies of the January 1886, July 1887, January 1937, January 1943, March 1943, September 1943, November 1943, July 1944, September 1944, January 1945, March 1945, May 1945, March 1947, February 1950, March 1950, October 1950 issue of the AMERICAN JOURNAL OF PSYCHIATRY, which are missing from our files.

---

* This office offers for sale the ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY, 1844-1944, deluxe edition for $15.00.

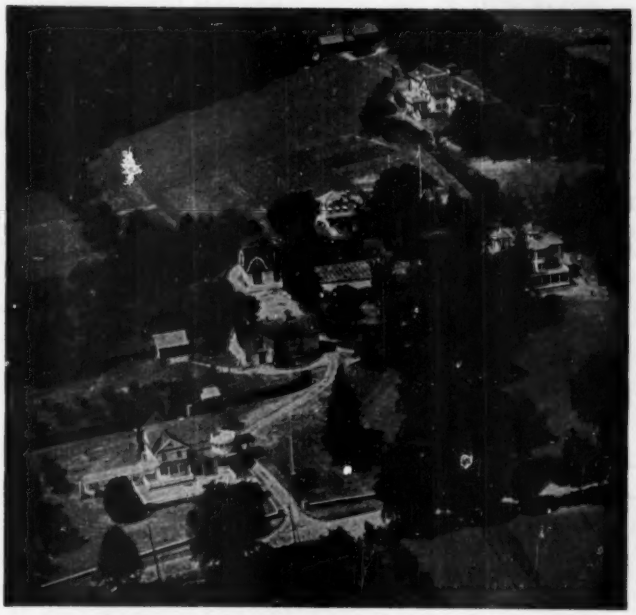
---

* In regard to the above, please contact Mr. Austin M. Davies, Room 412, 1270 Avenue of the Americas, New York 20, New York.

HALL-BROOKE

A modern psychiatric hospital in a non-institutional setting

(Licensed by State of Connecticut)



Dynamically-oriented psychotherapy

Electro-coma

Insulin full coma

Occupational and Recreational therapy

120 acre estate in Fairfield County

Tactful segregation of psychotic, alcohol and addiction cases and of psychoneurotic patients in separate buildings.

Tasteful Colonial decor

RATES

Begin at $85 All private rooms

Write or telephone for full information

(Mrs.) Heide F. Jones-Bernard, *Administrator* George K. Pratt, M. D., *Medical Director*

New York City Office: 133 East 58th Street PLaza 5-2570

Thursdays: 2-5 o'clock

HALL-BROOKE

Greens Farms (Westport), Connecticut Phone: Westport 2-5105

Only one hour from New York. Easily accessible from any part of Connecticut.

HIGH POINT HOSPITAL

PORT CHESTER, NEW YORK

POrt Chester 5-4420

Emphasis is on analytically oriented psychotherapy, each patient receiving a minimum of three therapeutic hours per week. Physiologic forms of treatment are available; therapy administered by attending psychoanalysts, and residents in advanced training under the immediate supervision of the director; staff of medical and surgical consultants; near New York City.

ALEXANDER GRALNICK, M.D., F.A.P.A., *Director*

WILLIAM V. SILVERBERG, M.D., F.A.P.A.
Chief Consultant in Psychotherapy

STEPHEN P. JEWETT, M.D.
Chief Consultant in Clinical Psychiatry

RUTH FOX, M.D.
Associate Consultant

L. CLOVIS HIRNING, M.D.
Associate Consultant

Attending Psychotherapists:

I. WM. BRILL, M.D.
LEONARD FRANK, M.D.
SYLVIA GENNIS, M. D.
LEONARD GOLD, M.D., F.A.P.A.
DANIEL GOLDSTEIN, M.D., F.A.P.A.
STEPHEN KEMPSTER, M.D.
SIMON NAGLER, M.D.
MERVYN SCHACHT, M.D.

ANTHONY W. ESPOSITO, M.H.A.
Hospital Administrator

LEATRICE STYRT SCHACHT, M.A.
Psychologist

LOIS CARLSEN, R.N.
Directress of Nurses

SAINT ALBANS SANATORIUM

RADFORD, VIRGINIA

100 bed private psychiatric hospital for the treatment of nervous and mental disorders, including alcoholism and addiction.

JAMES P. KING, M. D.
Director

JAMES K. MORROW, M. D.
THOMAS E. PAINTER, M. D.
DANIEL D. CHILES, M. D.
WENDELL T. WINGETT, M. D.

JAMES L. CHITWOOD, M. D.
Medical Consultant

"URGENT"

This office would like to obtain by purchase or by gift copies of the January 1886, July 1887, October 1888, February 1950 and the October 1950 issues of the AMERICAN JOURNAL OF PSYCHIATRY, which are missing from our files. Please notify Mr. Austin M. Davies; Room 412, RKO Building, 1270 Avenue of the Americas, New York 20, New York, if you know of the availability of these issues.